AGENDA – PUBLIC

Canterbury District Health Board
Te Poari Hauora o Waitaha

CANTERBURY DISTRICT HEALTH BOARD MEETING

To be held in the Board Room, Level 1, 32 Oxford Terrace, Christchurch
Thursday, 15 November 2018 commencing at 9.00am

	Karakia		9.00am
	Apologies		
1.	Conflict of Interest Register		
2.	Confirmation of Minutes: • Ordinary Meeting – 18 October 2018 • Special Meeting – 30 October 2018		
3.	Carried Forward / Action List Items		
4.	Patient Story		
5.	Appointment of Electoral Officer	Justine White	9.05-9.15am
6.	Sugar-Sweetened Beverages Position Paper	Dr Ramon Pink	9.15-9.25am
7.	Chair's Update - Oral	Dr John Wood	9.25-9.30am
8.	Chief Executive's Update	David Meates	9.30-10.00am
9.	Seeing Our System – Presentation	Carolyn Gullery	10.00-10.30am
MORNING TEA			**10.30-10.45am**
10.	Finance Report	Justine White	10.45-10.55am
11.	Maori and Pacific Health Progress Report	Hector Matthews	10.55-11.05am
12.	CPH&DSAC – 1 November 2018 – Draft Minutes	Dr Anna Crighton	11.05-11.10am
13.	Resolution to Exclude the Public		11.10am
ESTIMATED FINISH TIME – PUBLIC MEETING			**11.10am**

NEXT MEETING: Thursday, 13 December 2018 at 9.00am

ATTENDANCE

Canterbury District Health Board
Te Poari Hauora ō Waitaha

CANTERBURY DISTRICT HEALTH BOARD MEMBERS

Dr John Wood (Chair)
Ta Mark Solomon (Deputy Chair)
Barry Bragg
Sally Buck
Tracey Chambers
Dr Anna Crighton
Andrew Dickerson
Jo Kane
Aaron Keown
Chris Mene
David Morrell

Executive Support

David Meates – *Chief Executive*
Evon Currie – *General Manager, Community & Public Health*
Michael Frampton – *Chief People Officer*
Mary Gordon – *Executive Director of Nursing*
Carolyn Gullery – *Executive Director Planning, Funding & Decision Support*
Jacqui Lunday-Johnstone – *Executive Director of Allied Health, Scientific & Technical*
Hector Matthews – *Executive Director Maori & Pacific Health*
Sue Nightingale – *Chief Medical Officer*
Karalyn Van Deursen – *Executive Director of Communications*
Stella Ward – *Chief Digital Officer*
Justine White – *Executive Director Finance & Corporate Services*

Anna Craw – *Board Secretariat*
Charlotte Evers – *Assistant Board Secretariat*
Kay Jenkins – *Executive Assistant, Governance Support*

CONFLICTS OF INTEREST REGISTER CANTERBURY DISTRICT HEALTH BOARD (*CDHB*)

Canterbury District Health Board
Te Poari Hauora ō Waitaha

(As disclosed on appointment to the Board/Committee and updated from time-to-time, as necessary)

Dr John Wood **Chair CDHB**	**Advisory Board NZ/US Council** – Member The New Zealand United States Council was established in 2001. It is a non-partisan organisation, funded by business and the Government, and committed to fostering and developing a strong and mutually beneficial relationship between New Zealand and the United States. The Advisory Board supports the day to day work of the Council by providing strategic and operational advice to both the Executive Board and the Executive Director. **Member of the Governing Board of the Office of Treaty Settlements, Ministry of Justice (as Chief Crown Treaty of Waitangi Negotiator)** – Ex-Officio Member The Office of Treaty Settlements, Ministry of Justice, are responsible for negotiating the settlement of historical Treaty of Waitangi claims, and the administration of the Marine and Coastal Area (Takutai Moana) Act 2011. They also advise and help claimant groups so they are ready to enter negotiations. **Chief Crown Treaty Negotiator for Ngai Tuhoe** Settlement negotiated. Deed signed and ratified. Legislation enacted. **Chief Crown Treaty Negotiator for Ngati Rangi** Settlement negotiated. Deed signed and ratified. Legislation awaiting enactment. **Chief Crown Treaty Negotiator, Tongariro National Park** Engagement with Iwi collective begins July 2018. **Chief Crown Treaty Negotiator for the Whanganui River** Settlement negotiated. Deed signed and ratified. Legislation enacted. **Chief Crown Negotiator & Advisor, Mt Egmont National Park Negotiations** High level agreement in principle reached. Aiming for deed of settlement end of 2018. **Governing Board, Economic Research Institute for ASEAN and East Asia (ERIA)** – Member ERIA is an international organisation that was established by an agreement of the leaders of 16 East Asia Summit member countries. Its main role is to conduct research and policy analysis to facilitate the ASEAN Economic Community building and to support wider regional community building. The governing board is the decision-making body of ERIA and consists of the Secretary General of ASEAN and representatives from each of the 16 member countries, all of whom have backgrounds in academia, business, and policymaking. **Kaikoura Business Recovery Grants Programme Independent Panel** – Member The Kaikoura Business Recovery Grants Programme was launched in May 2017 and is intended to support local businesses until State Highway One reopens by way of grants which can be applied for by eligible businesses. This programme is now closed.

	School of Social and Political Sciences, University of Canterbury – Adjunct Professor Teach into graduate and post graduate programmes in political science, trade policy and diplomacy – pro bono appointment. **Te Urewera Governance Board** –Member The Te Urewera Act replaces the Te Urewera National Parks Act for the governance and management of Te Urewera. The purpose of the Act is to establish and preserve in perpetuity a legal identity and protected status for Te Urewera for its intrinsic worth, its distinctive natural and cultural values, the integrity of those values, and for its national importance. Inaugural term as a Crown appointment, re-appointed as a Ngai Tuhoe nominee. **University of Canterbury (*UC*)** – Chancellor The University Council is responsible for the governance of UC and the appointment of the Vice-Chancellor. It sets UC's policies and approves degree, financial and capital matters, and monitors their implementation. **University of Canterbury Foundation** – Ex-officio Trustee The University of Canterbury Foundation, Te Tūāpapa Hononga o Te Whare Wānanga o Waitaha, is dedicated to ensuring that UC's tradition of excellence in higher education continues. From its earliest beginnings in 1873, philanthropic support and the generosity of donors and supporters has played a major part in making the university the respected institution it is today. The UC Foundation is dedicated to continuing that tradition. **Universities New Zealand** – Elected Chair, Chancellors' Group Universities New Zealand is the sector voice for all eight universities, representing their views nationally and internationally, championing the quality education they deliver, and the important contribution they make to New Zealand and New Zealanders.
Ta Mark Solomon **Deputy Chair CDHB**	**Claims Resolution Consultation – Senior Maori Leaders Group** – Member This is an Advisory Board to MSD looking at the claims process of those held under State care. **Deep South NSC (National Science Challenge) Governance Board** – Member The objective of Deep South NSC is set by Cabinet, and is to understand the role of the Antarctic and Southern Ocean in determining our climate and our future environment. Building on this objective, the mission was developed to guide our vision, research priorities and activities. **Greater Christchurch Partnership Group** – Member This is a central partnership set up to coordinate our city's approach to key issues. It provides a strong, joined up way of working and ensures agencies are travelling in the same direction (so they do not duplicate or negate each other's work). **He Toki ki te Rika / ki te Mahi** – Patron He Toki ki te Rika is the next evolution of Māori Trade Training re-established after the earthquakes to ensure Maori people can play a distinguished role in the Canterbury rebuild. The scheme aims to grow the next generation of Māori leadership in trades by building Māori capability in the building and infrastructure industries in Canterbury.

	Liquid Media Operations Limited – Shareholder Liquid Media is a start-up company which has a water/sewage treatment technology. **Maori Carbon Foundation Limited** – Chairman The Maori Carbon Foundation has been established to deliver environmental, social and economic benefits through the planting of permanent carbon forestry, to Maori and New Zealand landowners throughout the country. **Ngāti Ruanui Holdings** – Director Ngati Ruanui Holdings is the Investment and Economic Development Arm of Ngati Ruanui established to maximise profits in accordance with Te Runanga directions in Taranaki. **NZCF Carbon Planting Advisory Limited** – Director NZCF Carbon Planting Advisory Limited is a company that carries out the obligations in respect of planting and upskilling relating to the Maori Carbon Foundation Limited. **Oaro M Incorporation** – Member 'Oaro M' Incorporation was established in 1968. Over the past 46 years successive Boards have managed and maintained the whenua, located at 'Oaro M', Kaikōura, on behalf of its shareholders. Over time shareholders have requested the Board consider establishing an education grant in order to assist whānau with their educational aspirations. **Police Commissioners Māori Focus Forum** – Member The Commissioner of Police has a group of senior kaumatua and kuia who meet with him regularly to discuss issues of mutual interest and concern. Known as the Commissioner's Māori Focus Forum, the group helps guide policing strategy in regard to Māori and provides advice on issues of the moment. The Māori Focus Forum developed The Turning of the Tide with help from Police. The forum plays a governance role and helps oversee the strategy's implementation. **Pure Advantage** – Trustee Pure Advantage is comprised of business leaders who believe the private sector has an important role to play in creating a greener, wealthier New Zealand. It is a not-for-profit organisation that investigates and promotes opportunities for green growth. **QuakeCoRE** – Board Member QuakeCoRE is transforming the earthquake resilience of communities and societies through innovative world-class research, human capability development, and deep national and international collaborations. They are a Centre of Research Excellence (CoRE) funded by the New Zealand Tertiary Education Commission. **Rangitane Holdings Limited & Rangitane Investments Limited** - Chair The Rangitāne Group has these two commercial entities which serve to develop the commercial potential of Rangitāne's settlement assets. A Board of Directors oversee the governance of the commercial entities, and are responsible for managing Crown lease properties and exploring commercial development opportunities to support the delivery of benefits to Rangitāne members. **SEED NZ Charitable Trust** – Chair and Trustee SEED is a company that works with community groups developing strategic plans.

	Sustainable Seas NSC (National Science Challenge) Governance Board – Member This is an independent Board that reports to the NIWA Board and operates under the Terms and Conditions specified in the Challenge Collaborative Agreement. The Board is responsible for appointing the Director, Science Leadership Team, Kāhui Māori, and Stakeholder Panel for projects within the Sustainable Seas NSC. The Board is also responsible for approving projects within the Research and Business Plan and for allocating funding. **Te Ohu Kai Moana** – Director Te Ohu Kai Moana is an organisation that works to advance Maori interests in the marine environment, including customary commercial fisheries, aquaculture and providing policy and fisheries management advice and recommendations to iwi and the wider Maori community. **Te Waka o Maui** – Independent Representative Te Waka o Maui is a Post Settlement Governance Entity.
Barry Bragg	**Canterbury West Coast Air Rescue Trust** – Trustee The Trust has a services agreement with Garden City Helicopters for the provision of air rescue and air ambulance services. Garden City Helicopters has a long-term air ambulance contract with the CDHB. **CRL Energy Limited** – Managing Director CRL Energy Limited provides air quality testing and asbestos sampling and analysis services; methamphetamine contamination testing; dust; gas and noise workplace monitoring services in New Zealand. There is the potential for future work with the CDHB. **Farrell Construction Limited** - Chairman Farrell's Construction Limited is a commercial and light commercial construction company based in Christchurch. **New Zealand Flying Doctor Service Trust** – Chairman The Trust has a services agreement with Garden City Helicopters for the provision of air ambulance services. Garden City Helicopters has a long-term air ambulance contract with the CDHB. **Ngai Tahu Property Limited** – Chairman Potential for future property development work with the CDHB. Also, Ngai Tahu Property Limited manage first right of refusal applications from the CDHB on behalf of Te Runanga o Ngai Tahu.
Sally Buck	**Christchurch City Council (*CCC*)** – Community Board Member Chair of the Central/Linwood/Heathcote Community Board which has delegated responsibilities from the CCC. **Registered Resource Management Act Commissioner** From time to time, sit on Resource Management Act panels for the CCC. Specific interests will be declared at the time. **Rose Historic Chapel Trust** – Member Charitable voluntary body managing the operation of the Rose Historic Chapel, a CCC owned facility.

Tracey Chambers	**Chambers Limited** – Director Chambers Limited has clients and former clients that may mean a conflict or potential conflict arises. These will be discussed at the appropriate time if they arise. **Rata Foundation** – Trustee Rātā Foundation, formerly The Canterbury Community Trust, was established in 1988 and is one of New Zealand's largest philanthropic organisations. The Foundation holds in trust for Canterbury, Nelson, Marlborough and the Chatham Islands an endowment, or putea, of over half a billion dollars. Investment returns on their capital base enables them to make millions of dollars in grants each year to community organisations across their funding region.
Dr Anna Crighton	**Christchurch Heritage Limited** - Chair - Governance of Christchurch Heritage **Christchurch Heritage Trust** – Chair - Governance of Christchurch Heritage **Heritage New Zealand –** Honorary Life Member CDHB owns buildings that may be considered to have historical significance.
Andrew Dickerson	**Accuro (Health Service Welfare Society)** - Director Is a not-for-profit, member owned co-operative society providing health insurance services to employees in the health sector and (more recently) members of the public. Accuro has many members who are employees of the CDHB. **Canterbury Health Care of the Elderly Education Trust** - Chair Promotes and supports teaching and research in the care of older people. Recipients of financial assistance for research, education or training could include employees of the CDHB. **Canterbury Medical Research Foundation** - Member Provides financial assistance for medical research in Canterbury. Recipients of financial assistance for research, education or training could include employees of the CDHB. **Heritage NZ -** Member Heritage NZ's mission is to promote the identification, protection, preservation and conservation of the historical and cultural heritage of New Zealand. It identifies, records and acts in respect of significant ancestral sites and buildings. CDHB owns buildings that may be considered to have historical significance and Heritage NZ has already been involved with CDHB buildings. **Maia Health Foundation -** Trustee Is a charitable trust established to support health care in the CDHB area. Current projects include fundraising for a rooftop helipad and enhancements to the children's wards at Christchurch Hospital. **NZ Association of Gerontology** - Member Professional association that promotes the interests of older people and an understanding of ageing.

Jo Kane	**HurriKane Consulting** – Project Management Partner/Consultant A private consultancy in management, communication and project management. Any conflicts of interest that arise will be disclosed/advised. **Latimer Community Housing Trust** – Project Manager

	Delivers social housing in Christchurch for the vulnerable and elderly in the community. **NZ Royal Humane Society** – Director Provides an awards system for acts of bravery in New Zealand. It is not anticipated any conflicts of interest will arise.
Aaron Keown	**Christchurch City Council** – Councillor and Community Board Member Elected member and of the Fendalton/Waimairi/Harewood Community Board.
Chris Mene	**Canterbury Clinical Network** – Child & Youth Workstream Member **Core Education** – Director Has an interest in the interface between education and health. **Wayne Francis Charitable Trust** - Board Member The Wayne Francis Charitable Trust is a philanthropic family organisation committed to making a positive and lasting contribution to the community. The Youth focussed Trust funds cancer research which embodies some of the Trust's fundamental objectives – prevention, long-term change, and actions that strive to benefit the lives of many.
David Morrell Board Member	**British Honorary Consul** Interest relates to supporting British nationals and relatives who may be hospitalised arising from injury related accidents, or use other services of CDHB, including Mental Health Services. A conflict of interest may also arise from time to time in respect to Coroners' inquest hearings involving British nationals. In addition, the British Foreign and Commonwealth Office (*FCO*) may expect Honorary Consuls to become involved in trade initiatives from time to time. **Canon Emeritus - Christchurch Cathedral** The Cathedral congregation runs a food programme in association with CDHB staff. **Friends of the Chapel** - Member **Great Christchurch Buildings Trust** – Trustee The Trust seeks the restoration of key Christchurch heritage buildings, particularly Christchurch Cathedral, and is also involved in facilitating the building of social housing. **Heritage NZ –** Subscribing Member Heritage NZ's mission is to promote the identification, protection, preservation and conservation of the historical and cultural heritage of New Zealand. It identifies, records and acts in respect of significant ancestral sites and buildings. CDHB owns buildings that may be considered to have historical significance. **Hospital Lady Visitors Association** - Wife is a member of this, but no potential conflict of interest is expected. Should one arise it will be declared at the time. **Nurses Memorial Chapel Trust** – Member (CDHB Appointee) Trust responsible for Memorial Chapel on the Christchurch Hospital site. Note the chapel is now owned by the Christchurch City Council.

MINUTES

Canterbury District Health Board
Te Poari Hauora o Waitaha

DRAFT
MINUTES OF THE CANTERBURY DISTRICT HEALTH BOARD MEETING
held at 32 Oxford Terrace, Christchurch
on Thursday 18 October 2018 commencing at 10.30am

BOARD MEMBERS

Dr John Wood (Chair); Ta Mark Solomon (Deputy Chair); Barry Bragg; Sally Buck; Tracey Chambers; Dr Anna Crighton; Andrew Dickerson; Jo Kane; Aaron Keown; Chris Mene; and David Morrell.

APOLOGIES

An apology was received and accepted from Andrew Dickerson for lateness (11.55am).

EXECUTIVE SUPPORT

David Meates (Chief Executive); Dr Greg Hamilton (Acting Executive Director, Planning Funding and Decision Support); Mary Gordon (Executive Director of Nursing); Helen Little (Interim Director of Allied Health); Hector Matthews (Executive Director Maori & Pacific Health); Sue Nightingale (Chief Medical Officer); Mick O'Donnell (Communications Team Leader); David Green (Financial Controller); Stella Ward (Chief Digital Officer); Anna Craw (Board Secretariat); and Kay Jenkins (Executive Assistant, Governance).

Hector Matthews opened the meeting with a Karakia.

1. INTEREST REGISTER

Additions/Alterations to the Interest Register
There were no additions or alterations to the Interest Register.

Declarations of Interest for Items on Today's Agenda
There were no declarations of interest for items on today's agenda.

Perceived Conflicts of Interest
There were no perceived conflicts of interest.

2. CONFIRMATION OF MINUTES OF THE PREVIOUS MEETING

Resolution (69/18)
(Moved: Sally Buck/seconded: Aaron Keown – carried)

"That the minutes of the meeting of the Canterbury District Health Board held at 32 Oxford Terrace on 20 September 2018 be confirmed as a true and correct record."

3. CARRIED FORWARD/ACTION LIST ITEMS

There were no carried forward items.

4. CHAIR'S UPDATE

Dr Wood commented that we are at that time of the year where there are a number of strategic issues we should take the time to discuss in the Public Excluded section of the meeting.

5. CHIEF EXECUTIVE'S UPDATE

David Meates, Chief Executive, took his report as read.

Resolution (70/18)
(Moved: Jo Kane/seconded: Chris Mene - carried)

"That the Board:

i. notes the Chief Executive's Update."

6. FINANCE REPORT

David Green, Financial Controller, presented the Finance Report which was taken as read.

Resolution (71/18)
(Moved: Jo Kane/seconded: Ta Mark Solomon – carried)

"That the Board:

i. notes the financial result and related matters for the period ended 31 August 2018.

7. BNZ TRANSITION

David Green, Financial Controller, presented this report which was taken as read.

Resolution (72/18)
(Moved: Barry Bragg/seconded: Sally Buck – carried)

"That the Board:

i. approves the delegations to open and amend any changes to all bank accounts to be set up with the BNZ in the name of Canterbury District Health Board. Canterbury DHB positions with authority to authorise any of these changes are any two from the list below:

- Board Chair
- Quality, Finance, Audit and Risk Committee Chair
- Chief Executive
- Executive Director, Finance & Corporate Services
- Financial Controller."

8. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (73/18)
(Moved: Sally Buck/Seconded: Ta Mark Solomon – carried)

"That the Board:

i resolves that the public be excluded from the following part of the proceedings of this meeting, namely items 1, 2, 3, 4, 5 and the information items contained in the report;

ii. notes that the general subject of each matter to be considered while the public is excluded and the reason for passing this resolution in relation to each matter and the specific grounds under Schedule 3, Clause 32 of the Act in respect to these items are as follows:

	GENERAL SUBJECT OF EACH MATTER TO BE CONSIDERED	GROUND(S) FOR THE PASSING OF THIS RESOLUTION	REFERENCE – OFFICIAL INFORMATION ACT 1982 (Section 9)
1.	Confirmation of minutes of the public excluded meeting of 20 September 2018	For the reasons set out in the previous Board agenda.	
2.	Draft Annual Report 2017/18	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
3.	Catheter Laboratory 1 Replacement	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
4.	Chair & Chief Executive's Update on Key Strategic Issues	Protect the privacy of natural persons. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	S9(2)(a) s9(2)(j)
5.	Annual Plan Delegations	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)

iii notes that this resolution is made in reliance on the Act, Schedule 3, Clause 32 and that the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist under any of sections 6, 7 or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982."

The Public meeting concluded at 10.40am.

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Dr John Wood, Chairman Date

MINUTES – SPECIAL MEETING

Canterbury District Health Board
Te Poari Hauora ō Waitaha

MINUTES OF THE CANTERBURY DISTRICT HEALTH BOARD SPECIAL MEETING
held at 32 Oxford Terrace, Christchurch
on Tuesday 30 October 2018 commencing at 12noon

BOARD MEMBERS

Dr John Wood (Chair); Barry Bragg; Tracey Chambers; Dr Anna Crighton; Andrew Dickerson; Jo Kane; Aaron Keown; David Morrell; and Ta Mark Solomon.

APOLOGIES

Apologies for absence were received and accepted from Sally Buck and Chris Mene.
An apology for lateness was received and accepted from Tracey Chambers (1.05pm).

EXECUTIVE SUPPORT

David Meates (Chief Executive); Mary Gordon (Executive Director of Nursing); Carolyn Gullery (Executive Director, Planning Funding & Decision Support); Michael Frampton (Chief People Officer); Dr Greg Hamilton (Planning & Funding); Helen Little (Interim Director of Allied Health); Hector Matthews (Executive Director Maori & Pacific Health); Sue Nightingale (Chief Medical Officer); Karalyn van Deursen (Executive Director of Communications); Stella Ward (Chief Digital Officer); Justine White (Executive Director, Finance & Corporate Services); Anna Craw (Board Secretariat); and Kay Jenkins (Executive Assistant, Governance Support).

Hector Matthews opened the meeting with a Karakia.

1. INTEREST REGISTER

Additions/Alterations to the Interest Register
There were no additions or alterations to the Interest Register.

Declarations of Interest for Items on Today's Agenda
There were no declarations of interest for items on today's agenda.

Perceived Conflicts of Interest
There were no perceived conflicts of interest.

2. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (74/18)
(Moved Jo Kane/seconded Ta Mark Solomon - carried)

"That the Board:

i resolves that the public be excluded from the following part of the proceedings of this meeting, namely item 1;
ii. notes that the general subject matter to be considered while the public is excluded, the reason for passing this resolution in relation to this matter, and the specific grounds under Schedule 3, Clause 32 of the Act in respect to this item, are as follows:

	GENERAL SUBJECT OF EACH MATTER TO BE CONSIDERED	GROUND(S) FOR THE PASSING OF THIS RESOLUTION	REFERENCE – OFFICIAL INFORMATION ACT 1982 (Section 9)
1.	Strategic Issues	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)

iii notes that this resolution is made in reliance on the Act, Schedule 3, Clause 32 and that the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist under any of sections 6, 7 or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982."

There being no further business the public meeting closed at 12.05pm.

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Dr John Wood, Chair Date

CARRIED FORWARD/ACTION ITEMS

Canterbury District Health Board
Te Poari Hauora ō Waitaha

CANTERBURY DISTRICT HEALTH BOARD
CARRIED FORWARD ITEMS AS AT 15 NOVEMBER 2018

DATE	ISSUE	REFERRED TO	STATUS
20 Sep 18	Presentation on IT systems; continual enhancement & ongoing use of data throughout the health system.	Stella Ward	To be scheduled for early 2019
20 Sep 18	Following on from Water NZ Conference & Expo 2018 - water issues update once direction of travel and legislation becomes clear.	Evon Currie	To be scheduled

APPOINTMENT CDHB ELECTORAL OFFICER

Canterbury District Health Board
Te Poari Hauora ō Waitaha

TO: **Chair and Members**
Canterbury District Health Board

SOURCE: **Corporate Services**

DATE: **15 November 2018**

Report Status – For:	Decision	☑	Noting	☐	Information	☐

1. ORIGIN OF THE REPORT

The purpose of this report is to seek confirmation to the appointment of a Canterbury DHB Electoral Officer (*EO*) and to outline a number of procedural matters relating to the 2019 District Health Board (*DHB*) elections that require Board approval.

Similar Board decisions were required by legislation prior to the 2016 elections. This paper's recommendations are consistent with those adopted by the Board in 2015.

2. RECOMMENDATION

That the Board:

i. confirms the continued appointment of Anthony Morton as the Canterbury DHB Electoral Officer, in accordance with the Local Electoral Act 2001; and
ii. adopts "random" as the order of candidates' names on Canterbury DHB voting documents, as permitted under Clause 31(1) of the Local Electoral Regulations 2001.

3. SUMMARY

The Canterbury DHB elections are required every three years at the same time as Territorial Local Authority (*TLA*) elections and will be held on 12 October 2019 (see Appendix 1 for the election timetable). Each DHB is to have seven elected members, with the Minister of Health being able to appoint up to four additional members to each Board.

As in 2016, the formal issues requiring Board approval are:

- the appointment of the Electoral Officer; and
- the determination of the order of candidate's names on voting papers.

By legislation, the District Health Board's EO continues in the role of EO unless he or she dies, resigns, is dismissed or becomes otherwise incapable of performing the role. The Canterbury DHB's EO in the 2016 triennial election was Anthony Morton of Electionz.com, whose contract has now expired. An appointment is therefore required for the 2019 year from one of the seven current TLA EOs in the Canterbury DHB area. Mr Morton is the TLA EO for Kaikoura, Hurunui, Waimakariri, Selwyn and Ashburton District Councils.

DHBs are able to decide what order candidates' names will appear on the DHB voting documents. Candidates' names are able to be listed in three ways: alphabetical order by surname, pseudo-random order, or random order.

The merits of each are discussed further in the paper, with a recommendation of "random" order, in alignment with the practice of most TLAs in the previous elections, and consistent with previous CDHB elections.

4. DISCUSSION

Electoral Officer Appointment

The NZ Public Health and Disability Act 2000, Schedule 2, Clause 9B requires the Canterbury DHB Board to appoint an EO from among the EOs of the seven TLAs within the Canterbury DHB district (Kaikoura, Hurunui, Waimakariri, Selwyn and Ashburton District Councils, Christchurch City Council, and the Chatham Islands).

The functions of that DHB EO are set out in the Local Electoral Act 2001 and the New Zealand Public Health and Disability Act 2000. In addition, a Memorandum of Understanding for DHB Elections, between the Ministry of Health and the NZ Society of Local Government Managers (*SOLGM*), outlines the different responsibilities of the DHB, the DHB EO, and any remaining TLA EOs.

Mr Anthony Morton, employed by Electionz.com, is the current EO for Kaikoura, Hurunui, Waimakariri, Selwyn and Ashburton District Councils. Electionz.com is the service provider / contractor to most of the TLAs in the South Island and provided election services in 2004, 2007, 2010, 2013 and 2016.

Approval is being sought from the Board at this early stage to allow planning to commence for the 2019 year.

Order of Candidates Names

DHBs and TLAs are entitled to determine the order in which their candidates' names will appear.

The Board is required to pass a resolution to have candidates' names arranged either in:

a. alphabetical order by surname;
b. pseudo-random order; or
c. random order.

In 2004, 2007, 2010, 2013 and 2016 "random" order was chosen.

Alphabetical has the candidates being listed in the same order as they are in the accompanying candidate profile booklet. However, it would most likely not be in the same order as most TLA voting documents. If the Board does not pass a resolution on the order of candidate names, then alphabetical order by surname is the default arrangement.

Pseudo-random means the same random order of candidates for each voting document (ie., the random order is determined prior to printing the voting documents and is the same on all documents).

Random means fully random order of candidates for every voting document - every single voting document could have a different order to it. This option is seen as avoiding the possibility of unfair advantage if electors choose to vote or rank candidates in descending order from the top of the list.

It is recommended that "random" be used for the candidate order on the Canterbury DHB voting documents, as being the option most likely to avoid any bias in voting.

Other Issues

The Memorandum of Understanding, between the Ministry of Health and SOLGM details the roles and responsibilities of the DHB, DHB EO and TA EOs and also dictates the rate at which the DHBs will pay TLAs for elections.

Schedule 2 of the New Zealand Public Health and Disability Act 2000 requires the cost of DHB elections to be borne by DHBs. Since 2007, DHBs have had to fund the election costs themselves.

Selwyn District Council is one of nine councils that have expressed an interest in trialling online voting in 2019. At this stage we are not certain of the impact that this may have on our election process. There are a number of issues and considerations to be addressed before a final decision is taken, which is not expected until late 2019.

As with the 2016 Election, guidelines for Canterbury DHB staff and Board members will be presented in 2019, to ensure transparency and best practice is established before any campaigning for the 2019 DHB elections begins. An information pack for candidates will also be prepared.

5. CONCLUSION

It is recommended that Anthony Morton (EO for Kaikoura, Hurunui, Waimakariri, Selwyn and Ashburton District Councils), be confirmed as the Canterbury DHB's EO for the 2019 elections and that he begin working with the other TLAs in the region with regard to protocols and requirements for the Canterbury DHB voting documents.

As previously, it is recommended that "random" order be used as the order of candidates' names on the voting documents. The Board should note that if no resolution is passed, then under the regulations the default arrangement is alphabetical order by surname.

6. APPENDICES

Appendix 1: 2019 Local Government Election Timetable

Report prepared by: Anna Craw, Board Secretariat

Report approved for release by: Justine White, Executive Director, Finance & Corporate Services

2019 Local Government Election Timetable

After 1 February 2019	Declaration of Electoral Officer and Deputy Electoral Officer
1 March - 30 April	Ratepayer Roll Enrolment Confirmation Forms Sent to existing ratepayers
1 March - 3 July	Preparation of Ratepayer Roll
13 March	EEC questionnaire sent to EOs
10 April	Final representation review decisions by Local Government Commission
1 May - 31 May	National Public Notice of Ratepayer Roll Qualifications and Procedures
9 May (Thursday)	EEC test data sent to EOs
25 June (Monday) By 28 June	EEC Enrolment Update Campaign commences Order of Candidate Names Resolution (optional)
1 July 5 July (Friday)	Check it Electoral Roll closes Receive Preliminary Electoral Rolls from EEC
Monday 8 July to Wednesday 17 July	Compile Preliminary Electoral Roll
10 July (Wednesday)	First public notice completed and booked with ad agency
15 July (Monday)	Nomination forms, Candidate Information Pack and Preliminary Rolls completed and all documents dispatched to Councils
17 July (Wednesday)	**Public Notice of Election** **(First Public Notice of Election)** Preliminary Electoral Roll Inspection, Nomination of Candidates, Closing Date of Electoral Roll
19 July (Friday)	**Nominations open/Roll Open for Inspection**
By 31 July	Appointment of JPs
16 August (Friday)	**Nominations Close (12 noon), Electoral Roll Closes** (2nd public notice confirmed with ad agency)
21 August (Wednesday)	**Public Notice of Candidates** **(Second Public Notice of Election)**
By 23 August (Friday)	Receive final Electoral Roll from EEC
16 August to 16 September	Final Postal Sort Data to mailhouse Design and print voting papers, verify Candidate Profiles
By 30 August	Ratepayer Roll insert with rates notice
16 September (Monday)	EO certifies final roll – final rolls distributed by EO
20 September (Friday)	EEC letter sent to electors on Unpublished Roll
Prior to 16 September	Advertise Special Voting arrangements
20 September to 25 September **20 September to 12 October**	**Delivery of Voting Documents** **Voting Period** Progressive Roll Scrutiny, Progressive Processing, Special Voting Period
12 October 2019 (Saturday)	**Election Day - Voting Closes at Noon** Provisional Results available as soon as practicable after close of voting
8 – 13 October	Official Count – process special votes
17 October (Thursday)	**Official Result Declaration**
17 October to 23 October (as soon as practicable)	**Public Notice of Official Declaration of Election Results**
November 2019	EO Forum
Mid December	Return of Election Expenses Forms

POSITION STATEMENT ON SUGAR-SWEETENED BEVERAGES

Canterbury District Health Board
Te Poari Hauora ō Waitaha

TO: **Chair and Members**
Canterbury District Health Board

SOURCE: **Community and Public Health**

DATE: **15 November 2018**

Report Status – For:	Decision ☑	Noting ☐	Information ☐

1. ORIGIN OF THE REPORT

The South Island Public Health Partnership has agreed the attached position statement and is now seeking approval from each of the DHBs.

2. RECOMMENDATION

That the Board, as recommended by the Community & Public Health and Disability Support Advisory Committee:

i. endorses the South Island District Health Boards' position statement on sugar-sweetened beverages.

3. APPENDICES

Appendix 1: South Island DHBs' Position Statement on Sugar-Sweetened Beverages
Appendix 2: Background Paper: Sugar-Sweetened Beverages

Report prepared by: South Island Public Health Partnership

Report approved for release by: Evon Currie, General Manager, Community & Public Health

APPENDIX 1

South Island District Health Boards' Position statement on sugar-sweetened beverages

SOUTH ISLAND DISTRICT HEALTH BOARDS' POSITION

What sugar-sweetened beverages mean for health

The South Island District Health Boards:

- Consider nutrition to be a key determinant of health and wellbeing.
- Acknowledge that sugar-sweetened beverages[1] are a significant source of sugar in the diet of New Zealanders, are energy-dense and nutrient-poor, and displace healthier food and beverage options.
- Recognise that regular consumption of sugar-sweetened beverages contributes to obesity and dental caries, and is associated with a number of non-communicable diseases including type 2 diabetes.
- Acknowledge that non-communicable diseases contribute to significant personal, social and economic costs to individuals, whānau, communities, and the public health system in New Zealand.
- Understand that non-communicable diseases are a cause of health inequities in New Zealand.
- Recognise that District Health Boards play a role in non-communicable disease prevention through supporting health-promoting environments.

What can be done to reduce the harm from sugar-sweetened beverages

The South Island District Health Boards:

- Show leadership by providing healthy eating environments on their premises for staff, visitors, and the public with the implementation of a healthy food and beverage policy.
- Endorse plain water as the first choice of drink for children and adults as recommended by the Ministry of Health.
- Support evidence-based interventions to reduce sugar-sweetened beverage consumption by:
    - decreasing the availability, affordability and marketing of sugar-sweetened beverages, and
    - increasing awareness of the sugar content of sugar-sweetened beverages, associated negative health outcomes and alternative beverage options.

[1] Any beverage that contains added caloric sweetener, usually sugar. The main categories of sugary drinks include soft-drinks/fizzy-drinks, sachet mixes, fruit drinks, cordials, flavoured milks, cold teas/coffees, and energy/sports drinks (New Zealand Beverage Guidance Panel, 2014b).

APPENDIX 2

Background Paper: Sugar-Sweetened Beverages

Why focus on sugar-sweetened beverages?

Sugar-sweetened beverages[2] (*SSBs*) are one of the main sources of sugar in the diets of New Zealand adults and children (Parnell et al., 2003; University of Otago & Ministry of Health, 2011), are energy-dense and nutrient-poor, and displace healthier food and beverage options (World Health Organization, 2016a). Regular consumption of SSBs is associated with an increased risk of obesity, dental caries, and other non-communicable diseases (*NCDs*) including type 2 diabetes and coronary heart disease. In addition, decreasing SSB intake improves health outcomes (Hu, 2013). NCDs contribute to significant, and in many cases preventable, personal, social and economic costs to individuals, whānau, communities, and the public health system in New Zealand (Ministry of Health, 2009, 2016c). The burden of NCDs is unequally distributed within the New Zealand population, and is a cause of considerable health inequities (Ministry of Health, 2009). Globally, it was estimated that in 2010, almost 300,000 deaths (about 0.6 percent) were attributable to diets high in SSBs (Lim et al., 2012).

Sugar intake recommendations and sugar-sweetened beverage consumption in Aotearoa New Zealand

The World Health Organization recommends reducing the intake of free sugars3 to less than 10 percent of total energy intake for adults and children, excluding sugars found in whole fruits and vegetables, and milk. That is approximately 50 grams, or 12 teaspoons, per day for adults (The Royal Society of New Zealand, 2016). Further reductions of free sugars to less than 5 percent of total energy intake (around 6 teaspoons for adults and 3-5 teaspoons for children) could provide additional health benefits (World Health Organization, 2015).

Beverages (including SSBs) are the largest contributors of free sugars to the diet of New Zealand children and adults, providing 24 percent of the total sugar[4] intake of children (Parnell et al., 2003) and 17 percent of the total sugar intake of adults (University of Otago et al., 2011). The New Zealand Ministry of Health recommends that children and adults limit their intake of sugary drinks because they are high in sugar and energy, and contain few (if any) beneficial nutrients (Ministry of Health, 2012, 2015a). Some also contain stimulants, such as caffeine, which are inappropriate for children (Ministry of Health, 2012). However, in New Zealand, the consumption of SSBs is common among children, adolescents and adults (Clinical Trials Research Unit & Synovate, 2010; Ministry of Health, 2016a; Parnell et al., 2003; Sundborn, Gentles, & Metcalf, 2014a; Sundborn et al., 2014c; University of Otago et al., 2011).

In the most recent New Zealand Health Survey, 54 percent of children (2-14 years of age) reported having "fizzy drink" at least once in the past week, and 18 percent had it three or more times in the past week (Ministry of Health, 2016a). Among secondary school students participating in a national survey in 2007, 29 percent consumed "fizzy or soft drinks" four or more times per week, 45 percent consumed them 1-3 times per week, and 26 percent had not consumed any in the last week (Sundborn et al., 2014c).

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[2] Any beverage that contains added caloric sweetener, usually sugar. The main categories of sugary drinks include soft-drinks/fizzy-drinks, sachet mixes, fruit drinks, cordials, flavoured milks, cold teas/coffees, and energy/sports drinks (New Zealand Beverage Guidance Panel, 2014).

[3] Free sugars include monosaccharides and disaccharides added to foods and beverages by the manufacturer, cook or consumer, and sugars naturally present in honey, syrups, fruit juices and fruit juice concentrates (World Health Organization, 2015).

[4] Total sugars include free sugars (see definition above), intrinsic sugars (those incorporated within the structure of intact fruit and vegetables), and milk sugars (lactose and galactose) (World Health Organization, 2015).

In a nationwide survey of New Zealand adults (15 years of age and over) conducted in 2008/2009, seven percent of respondents reported drinking "soft" or "energy" (not including "diet") drinks daily, and 24 percent reported drinking them three or more times a week (University of Otago et al., 2011). Fruit juice and fruit drinks were consumed more often, with 14 percent of respondents drinking them daily, and 37 percent drinking them three or more times a week (University of Otago et al., 2011). In addition, SSB intake among children, adolescents and adults in New Zealand is significantly higher among Māori, Pacific peoples, and those living in neighbourhoods with high deprivation scores (Kruse, 2014a; Ministry of Health, 2016a; Sundborn et al., 2014a; Sundborn et al., 2014c; University of Otago et al., 2011).

Sugar-sweetened beverage consumption and health outcomes

Overweight and obesity

Excess weight is a leading contributor to a number of significant NCDs, including type 2 diabetes, cardiovascular diseases, several cancers, osteoarthritis, gout, sleep apnoea, and reproductive disorders (Guh et al., 2009; Ministry of Health, 2015b, 2016a). In addition, being overweight or obese in childhood is associated with a variety of physical, social and mental health problems, including low self-esteem and quality of life, high blood cholesterol, blood glucose and blood pressure, and obstructive sleep apnoea (Daniels et al., 2005; Friedemann et al., 2012; Griffiths, Parsons, & Hill, 2010; Lobstein et al., 2004; Mathew & Narang, 2014; Pulgarón, 2013; World Health Organization, 2016a). Obese children are also more likely to become obese adults (Kelsey et al., 2014; Singh et al., 2008) and develop NCDs such as type 2 diabetes and cardiovascular diseases at a younger age (Daniels et al., 2005; Kelsey et al., 2014; Lobstein et al., 2004; Reilly & Kelly, 2011; World Health Organization, 2012, 2016a).

High body mass index (BMI) was the leading modifiable risk to health in New Zealand in 2013, and accounted for approximately 9 percent of all illness, disability and premature mortality (Ministry of Health, 2016c). Obesity is a significant cause of preventable costs to the public health care system and society. Research undertaken in 2006 estimated that obesity cost New Zealand $847 million annually in health care costs and lost productivity (Lal et al., 2012).

New Zealand ranks third out of approximately 30 OECD countries for both adult and child obesity rates (Organisation for Economic Co-operation and Development, 2014). Nearly one third of New Zealand adults and one in nine children aged 2-14 years are obese, and a further 35 percent of adults and 21 percent of children, are overweight (Ministry of Health, 2015b, 2016a, 2016b). Overweight and obesity rates are significantly higher among Māori, Pacific peoples, and those living in areas with high deprivation scores (Ministry of Health, 2015b, 2016a, 2016b).

There is strong evidence that the consumption of free sugars is associated with weight gain (World Health Organization, 2015). Further, several recent systematic reviews and meta-analyses have found a significant association between higher SSB consumption and increased risk of overweight and obesity among children and adults (Bes-Rastrollo et al., 2013; Bucher Della Torre et al., 2015; Malik et al., 2013; Te Morenga, Mallard, & Mann, 2013; Woodward-Lopez, Kao, & Ritchie, 2011). Those who drank SSBs most often (usually one or more servings per day) were at a significantly higher risk of overweight and obesity than those who drank SSBs the least often (usually no, or infrequent, consumption). Also, the risk of overweight and obesity associated with SSB consumption tended to increase in a dose-dependent manner. There is also good evidence from prospective cohort studies and randomised controlled trials that consuming SSBs causes weight gain, and removing SSBs from the diet (or substituting SSBs with water or low-energy beverages)

can result in significantly lower energy intake and less weight gain in the long-term (Hu, 2013; Malik et al., 2013; Te Morenga et al., 2013; Woodward-Lopez et al., 2011; Zheng et al., 2015).

Evidence suggests that SSBs promote weight gain through excess energy intake, as consumers tend not to reduce their consumption of other foods and beverages sufficiently to compensate for the extra energy provided by SSBs (Bachman, Baranowski, & Nicklas, 2006; von Philipsborn et al., 2016; World Health Organization, 2014). This may be because SSBs do not provide feelings of satiety equivalent to their high energy content, and people tend to consume SSBs irrespective of hunger and satiety cues (Pan & Hu, 2011; von Philipsborn et al., 2016; World Health Organization, 2014).

Dental caries

Dental caries is the most common NCD globally (Marcenes et al., 2013), and is the most prevalent chronic and largely preventable disease in New Zealand (Ministry of Health, 2010). Approximately 29,000 New Zealand children, and 262,000 adults had one or more teeth extracted due to decay, abscess, infection or gum disease in 2015/2016 (Ministry of Health, 2016a). Dental care is one of the most common reasons for children's admission to hospital, and for young children dental disease is a leading cause of potentially avoidable hospitalisations (Craig et al., 2013; Whyman et al., 2014). Significant disparities in oral health status and access to dental services exist in New Zealand, particularly for Māori, Pacific people, and those living in areas with high deprivation scores (Ministry of Health, 2010, 2016a).

There is strong evidence that free sugar consumption is associated with dental caries (World Health Organization, 2015). Further, more frequent consumption of SSBs is significantly associated with increased risk of dental caries among both children and adults (Armfield et al., 2013; Bernabé et al., 2014; Broffitt et al., 2013; Evans et al., 2013; Kolker et al., 2007; Levy et al., 2003; Lim et al., 2008; Marshall et al., 2003; Park et al., 2015; Sohn, Burt, & Sowers, 2006; Tseveenjav et al., 2011; Vartanian, Schwartz, & Brownell, 2007; Warren et al., 2009). The high free sugar concentration of SSBs induces the proliferation of caries-causing bacteria in the mouth and their metabolism produces acids that cause demineralisation of tooth enamel and dentin, leading to the formation of caries (New Zealand Dental Association, 2016a). In addition, the acidic nature of many SSBs can cause tooth erosion (Tahmassebi et al., 2006).

Other non-communicable diseases and risk factors

A large proportion of the morbidity, disability, and premature mortality experienced by New Zealanders is attributable to NCDs, and there is significant potential to achieve health gains by focussing on disease prevention (Ministry of Health, 2016c). Several recent systematic reviews and meta-analyses have found significant associations between higher SSB consumption and increased risk of some NCDs (and their risk factors), including:

- type 2 diabetes (Greenwood et al., 2014; Imamura et al., 2015; Malik et al., 2010; Wang et al., 2015)
- coronary heart disease (Huang et al., 2014; Xi et al., 2015)
- gout (Singh, Reddy, & Kundukulam, 2011)
- non-alcoholic fatty liver disease (Wijarnpreecha et al., 2016),
- chronic kidney disease (Cheungpasitporn et al., 2014), and
- hypertension (Cheungpasitporn et al., 2015; Jayalath et al., 2015; Keller, Heitmann, & Olsen, 2015; Malik et al., 2014; Xi et al., 2015).

Interventions to reduce sugar-sweetened beverage consumption

SSBs would be a suitable target for intervention to improve the health of New Zealanders as their consumption is associated with negative health consequences, they are commonly consumed by children and adults, they provide little-to-no nutritional value, and removing them from the diet can result in positive health outcomes and improved health equity. However, decreasing SSB consumption among New Zealanders is a challenging prospect due to their relatively low cost, wide availability, high palatability, and pervasive marketing.

Many local and international health organisations support recommendations to decrease sugar (Public Health England, 2015a; World Cancer Research Fund International, 2015a; World Health Organization, 2015) and SSB consumption (Australian Prevention Partnership Centre, Deakin University, & INFORMAS, 2017; Beaglehole, 2014; Duckett, Swerissen, & Wiltshire, 2016; Faculty of Public Health, 2013; Khan et al., 2009; New Zealand Beverage Guidance Panel, 2014; New Zealand Dental Association, 2016a; New Zealand Medical Association, 2016; Toi Te Ora - Public Health Service, 2015; Yale Rudd Center for Food Policy and Obesity, 2014) as part of wider strategies to improve population health. Several commonly recommended environmental and behavioural strategies are summarised below, and it is acknowledged that implementing multiple complementary interventions would achieve the largest health gains with greater cost-effectiveness than any one strategy alone (Cecchini et al., 2010; World Health Organization, 2012).

Environmental strategies

The World Health Organization and World Cancer Research Fund International, among other organisations, highlight the need to create health-promoting food environments that enable the public to easily make healthy food choices, as part of multicomponent strategies to improve public health, and prevent and control NCDs (Hawkes, Jewell, & Allen, 2013; World Cancer Research Fund International, 2015b; World Health Organization, 2013). Environmental strategies to achieve this include decreasing the availability of unhealthy food and beverages in public institutions and workplaces, restricting their marketing to children, and increasing their price. These types of environmental strategies are some of the most effective and cost-effective or cost-saving) for governments in terms of public health interventions (Gortmaker et al., 2015; Gortmaker et al., 2011; Lehnert et al., 2012; Owen et al., 2012; Swinburn et al., 2011; Vos et al., 2010). “Upstream” interventions such as these are also more promising in reducing inequities between socioeconomic groups (Lorenc et al., 2013).

Decrease the availability of sugar-sweetened beverages in public institutions and other specific settings

The World Health Organization recommends public institutions (such as hospitals and other health care settings, education and child-care facilities, government agencies, and prisons) create healthy food environments by not providing or selling unhealthy foods and beverages (World Health Organization, 2013, 2016a). Local health advocates support the introduction of guidelines for organisations and workplaces that decrease the availability of SSBs, where water and unflavoured milk are the main cold drink options provided (New Zealand Beverage Guidance Panel, 2014; New Zealand Dental Association, 2016a; Toi Te Ora - Public Health Service, 2015).

Some steps towards decreasing the availability of SSBs in New Zealand have been made using settings-specific policies. In August 2015 the New Zealand Director General of Health requested that all district health boards implement a policy to remove SSBs from their premises by 30 September 2015 as part of a wider approach to reduce the incidence of obesity. In September 2016, the National Healthy Food and Drink Policy was released, which aims to demonstrate commitment to the health of staff, visitors, patients, and the general public by providing food and

beverage options consistent with the Eating and Activity Guidelines for New Zealand Adults (National District Health Board Food and Drink Environments Network, 2016b). Individual district health boards can choose to adopt the policy, which states that SSBs will not be provided by the district health board and/or their contracted health service providers, or develop their own policy. The Ministry of Health adapted the policy for other New Zealand organisations and workplaces to tailor and/or adopt (National District Health Board Food and Drink Environments Network, 2016a). Further, the Health Promotion Agency (2013) has published guidelines for providing healthier beverage options in workplaces.

At a local government level, some local councils in New Zealand have introduced policies to support public health by limiting the availability of SSBs at council premises and events (Community & Public Health, 2015). For example, Nelson City Council has introduced a policy whereby SSBs will not be made available to staff and visitors within its facilities (Nelson City Council, 2015). Similarly, Marlborough District Council has adopted a policy which prevents SSBs being made available at its workplaces, functions or events where the Council is the main funder (Marlborough District Council, 2015).

The Ministry of Health is encouraging schools to adopt a healthy beverage policy of water and plain reduced-fat milk (Ministry of Health, 2016d), and the Health Promotion Agency provides a guide (Health Promotion Agency, 2016) and specific resources for schools. Schools are ideal settings to model healthy nutrition behaviours as in New Zealand around a third of a child's daily energy intake is consumed while at school (Regan et al., 2008), and many children frequent the school canteen (Parnell et al., 2003). Eliminating the provision and sale of SSBs on school premises would be a pro-equity approach, as consumption of food and beverages purchased at school is more common among Māori and Pacific children (Utter et al., 2007). There is also a high level of support from New Zealand parents and caregivers for schools to limit access to high fat foods, sugary drinks, and sugary foods (Holland, 2015).

Restrict marketing of sugar-sweetened beverages to children and adolescents

Food and beverage marketing to children has a role in developing children's food and beverage preferences, purchases, knowledge, and intake (Boyland & Whalen, 2015; Cairns, Angus, & Hastings, 2009; Cairns et al., 2013; Kraak & Story, 2015; Norman et al., 2016; Public Health England, 2015c). A range of methods are used to market to children, including television and online advertising, branded online games ("advergames"), gift-with-purchase, packaging, industry sponsorship of children's sports and community events, in-store product placement, and the use of licensed characters and celebrity endorsements (Agencies for Nutrition Action, 2013; Jenkin et al., 2014; Public Health England, 2015a; World Health Organization, 2010). In New Zealand, as elsewhere, food and beverages (including SSBs) high in sugar, salt and saturated fat are commonly marketed to children and adolescents across a wide variety of media and settings (Cairns et al., 2009; Carter et al., 2013; Hammond, Wyllie, & Casswell, 1999; Heart & Stroke, 2017; Jenkin, Wilson, & Hermanson, 2009; Maher, Wilson, & Signal, 2005; No et al., 2014; Vandevijvere & Swinburn, 2015; Wilson, Quigley, & Mansoor, 1999; Wilson et al., 2006; World Health Organization, 2010). Evidence suggests there is also an association between food and beverage marketing and poor diet quality and obesity (Cairns et al., 2013). In addition, there is valid concern about the ethics of marketing to children and adolescents, as young people are vulnerable to the effects of marketing due to their limited ability to critically analyse the content of persuasive messages (Calvert, 2008).

For some time public health advocates have called for government-led regulations to limit young people's exposure to the marketing of unhealthy food and beverages (including SSBs) (Agencies for Nutrition Action, 2013; Australian Prevention Partnership Centre et al., 2017; Heart & Stroke,

2017; New Zealand Beverage Guidance Panel, 2014; New Zealand Dental Association, 2016a; New Zealand Medical Association, 2014; Toi Te Ora - Public Health Service, 2015; World Cancer Research Fund International, 2015a; World Health Organization, 2010, 2012, 2016b). There is also some support among New Zealand parents and caregivers for restricting the marketing of unhealthy food and beverages to children (Gendall et al., 2015; Kruse, 2014b).

The restriction of television food and beverage advertising to children is estimated to be one of the most cost-effective population-based interventions available to governments to reduce the consumption of energy-dense, nutrient-poor food and beverages (Gortmaker et al., 2015; Magnus et al., 2009). While television advertising has been the focus of much of the research to date, it is recommended that restrictions cover wider aspects of marketing, particularly as the use of marketing to young people via digital media (e.g. via websites, apps, text messages and social media) is increasing (Kelly et al., 2015; Public Health England, 2015c; World Health Organization, 2010, 2016b).

Some countries including Sweden, Norway, and the Québec province in Canada have government regulations that restrict advertising (of any product) to children, and the UK, Ireland, Mexico, Chile and South Korea have restrictions on the advertising of certain food and beverages to children (Australian Prevention Partnership Centre et al., 2017; Galbraith-Emami & Lobstein, 2013; Heart & Stroke, 2017). Some food and beverage companies have responded with voluntary policies to market "healthier" options and lifestyles to children (Galbraith-Emami et al., 2013; Kraak et al., 2016). However, these types of voluntary codes do not appear to be making a significant impact on decreasing young people's exposure to unhealthy food and beverages, and mandatory regulations are recommended (Galbraith-Emami et al., 2013; Hawkes & Lobstein, 2011; Kunkel, Castonguay, & Filer, 2015; Vandevijvere et al., 2015).

Increase the purchase price of sugar-sweetened beverages

Price greatly influences food and beverage purchasing behaviours (Andreyeva, Long, & Brownell, 2010), and economic tools (such as taxes and subsidies) can be used to improve the affordability and encourage purchasing of healthier food and beverage products, and discourage the purchasing of less healthy options (Epstein et al., 2012; Eyles et al., 2012; Powell et al., 2013; Public Health England, 2015b; Thow et al., 2010; World Health Organization, 2013). The World Health Organization, among others, advocates the use of fiscal policies to improve diet quality at the population level (Hawkes et al., 2013; World Health Organization, 2013, 2016a). Further, numerous international and local organisations support specific taxes on SSBs and/or sugar to decrease their consumption and improve population health (Australian Chronic Disease Prevention Alliance, 2017; Australian Prevention Partnership Centre et al., 2017; Duckett et al., 2016; Faculty of Public Health, 2013; Hawkes et al., 2013; New Zealand Beverage Guidance Panel, 2014; New Zealand Dental Association, 2016a; New Zealand Medical Association, 2016; Toi Te Ora - Public Health Service, 2015; World Cancer Research Fund International, 2015a; World Health Organization, 2013, 2016a). A tax on SSBs is also recommended as it has the potential to reduce health disparities due to a greater impact on consumption among low-income consumers, whose purchases tend to be more price-sensitive, leading to greater possible health gains in this group (Backholer et al., 2016; Eyles et al., 2012; Ni Mhurchu et al., 2013; World Health Organization, 2016a).

There is evidence from several population-based policies currently in action supporting the use of taxes on SSBs to limit their consumption and decrease the prevalence of obesity. A meta-analysis of nine studies has investigated the impacts of SSB tax/price increases that have been implemented in the USA, Mexico, Brazil and France (Cabrera Escobar et al., 2013). It reported that higher prices were associated with a lower demand for SSBs, an increased demand for non-taxed

beverages, and a modest decrease in BMI and prevalence of overweight and obesity at the population level. One specific example is Mexico, where a tax on SSBs was introduced in January 2014 increasing their price by around 10 percent. Evaluation of the tax on purchases found that by December 2014, purchases of taxed drinks had declined by 12 percent overall with a greater reduction (17%) among lower socioeconomic status households, indicating that the tax was pro-equity (Colchero et al., 2016). Untaxed beverage sales increased by 4 percent, mainly due to an increase in bottled water sales. In addition it is estimated that the tax could significantly decrease diabetes and cardiovascular disease-related morbidity and mortality and reduce healthcare costs (Sánchez-Romero et al., 2016).

It has been estimated that a 20 percent tax on carbonated beverages in New Zealand would decrease intake by an estimated 19 percent (Eyles et al., 2012). Further, 60-73 premature deaths in New Zealand a year might be prevented, with up to $40 million of revenue raised annually (Ni Mhurchu et al., 2014). These modelling studies considered only carbonated beverages, so including other non-carbonated SSBs (e.g. fruit drinks) in the taxation strategy would enhance the estimated benefits and revenue further. Revenue from such a tax could be used to support health promotion programmes to improve population health (Ni Mhurchu et al., 2014). The authors state that the tax would likely reduce inequities in New Zealand as the impact would likely be larger amongst Māori consumers due to their greater responsiveness to changes in food prices, and amongst children and young people due to their higher consumption of these types of beverages (Ni Mhurchu et al., 2014).

Introduce mandatory nutrition label standards for sugar-sweetened beverages

Many consumers use nutrition labels on pre-packaged foods and beverages to inform their purchasing, and their use varies considerably across sub-groups, with lower label use among young people, older adults, males, ethnic minorities, and those on low incomes (Campos, Doxey, & Hammond, 2011). Individuals with healthier eating habits report higher use of nutrition labels (Campos et al., 2011; World Health Organization, 2012).

Nutrition labelling is a cost-effective population-level intervention with wide reach (Campos et al., 2011; Lehnert et al., 2012), and is endorsed as part of multicomponent strategies to improve population diet and prevent and control NCDs (World Health Organization, 2013). The use of simple “interpretive” labelling on the front of packs using symbols/graphics, logos and colours to guide consumers in understanding nutrition information, is recommended (World Health Organization, 2012). These types of labels are easier to interpret, and are particularly effective for people with lower nutrition-related knowledge (Campos et al., 2011; Cecchini & Warin, 2016; Hersey et al., 2013). Research from New Zealand also indicates that interpretive labels are more easily understood (Gorton et al., 2009; Ni Mhurchu et al., 2017) and accepted across ethnic groups and income levels (Gorton et al., 2009). Among those who use them most, interpretative labelling assists consumers to select healthier products to a small degree (Cecchini et al., 2016; Ni Mhurchu et al., 2017; World Health Organization, 2012). There is also some evidence that the use of front-of-pack symbols has provided an incentive for food manufacturers to reformulate their products with less salt, fat and sugar (Dummer, 2012; Vyth et al., 2010; Williams, McMahon, & Boustead, 2003; World Cancer Research Fund International, 2015a; Young & Swinburn, 2002).

In New Zealand, the Health Star Rating is a voluntary front-of-pack labelling system designed to help consumers make healthier food choices (Health Promotion Agency, 2015; Ministry for Primary Industries). It uses a graduated rating scale of stars ranging from half (least healthy) to 5 (most healthy) stars. However, as the system is voluntary not all food manufacturers will choose to use the system, or only use it for certain products, so consumers may not necessarily be able to compare all available options. To ensure that consumers can quickly and easily identify the sugar

content of SSBs, and compare different beverages, a mandatory labelling system with an evidence-based interpretive format is necessary. It is recommended that any interpretive front-of-pack labelling is supported by public education programmes on nutrition literacy for both adults and children (World Health Organization, 2016a).

Behavioural strategies

Behavioural strategies target the "dietary preferences, knowledge, attitudes, motivations, skills and abilities of individuals, as well as their subjective perception of social norms on food and beverage consumption." (von Philipsborn et al., 2016). Behavioural strategies targeted at individuals are more limited in their overall impact and cost-effectiveness as changes to an individual's behaviour requires support from health-promoting environments. Enhanced and longer-term effects of individual-level strategies are likely to occur when they are implemented in conjunction with population-based environmental strategies (World Health Organization, 2012).

Provide information on sugar-sweetened beverages through public awareness and nutrition education

To increase nutrition knowledge and literacy, disseminating nutrition information and guidelines for adults and children in ways that are understandable and accessible to all population groups is recommended (World Health Organization, 2016a). This includes evidence-based public awareness campaigns and social marketing initiatives to inform consumers about healthy dietary habits, and incorporating health and nutrition literacy into the school curriculum (World Health Organization, 2013, 2016a).

Social marketing and media campaigns targeting SSBs, implemented by health organisations, are increasing in number worldwide (Sundborn et al., 2014b). Previously in New Zealand the Health Sponsorship Council promoted water and milk as the first drink of choice for children and families in their "Feeding our Futures" campaign from 2007 (Sundborn et al., 2014b). More recently, the New Zealand Dental Association challenged New Zealanders to "Switch to water" as part of their annual oral health awareness campaign in November 2016 (New Zealand Dental Association, 2016b). Focussed social marketing campaigns can increase healthy eating practices to a small degree at an individual level (Carins & Rundle-Thiele, 2014). However it has been suggested that these universal "one-size-fits-all" media advertising approaches may contribute to further increasing health inequities as those with more resources are better able to implement the suggested behaviours (Frohlich & Potvin, 2008; Lorenc et al., 2013; Stead, Hastings, & McDermott, 2007).

School-based education programmes delivered as part of the school curriculum focussed on decreasing SSB intake can be effective at reducing SSB consumption and BMI, though follow-up sessions are necessary to ensure behaviour change is sustained (Avery, Bostock, & McCullough, 2015). The effectiveness of beverage-specific school-based education programmes could be increased by changes to the school environment, for example, by implementing milk- and water-only policies, and providing quality water fountains (Avery et al., 2015).

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CHAIR'S UPDATE

Canterbury District Health Board
Te Poari Hauora ō Waitaha

NOTES ONLY PAGE

CHIEF EXECUTIVE'S UPDATE

Canterbury District Health Board
Te Poari Hauora ō Waitaha

TO: **Chair and Members**
Canterbury District Health Board

SOURCE: **Chief Executive**

DATE: **15 November 2018**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

This report is a standing agenda item, providing the latest update and overview of key organisational activities and progress from the Chief Executive to the Board of the Canterbury DHB.

2. RECOMMENDATION

That the Board:

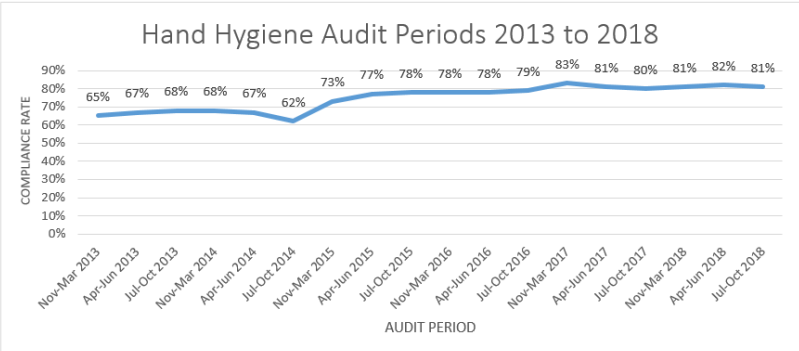
i. notes the Chief Executive's update.

3. DISCUSSION

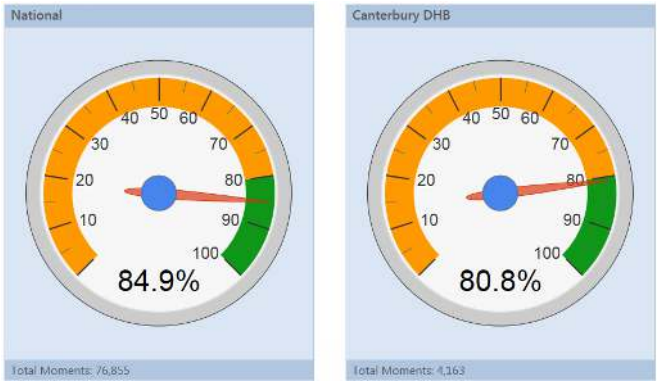
PUTTING THE PATIENT FIRST – PATIENT SAFETY

Quality & Patient Safety

- **Canterbury Health System Quality Improvement Showcase:** Awards will be presented at the Canterbury Health System Quality Improvement and Innovation Awards Showcase on 6 December. Submissions are assessed on how well they meet specific criteria; identifying the need and following the PDSA (Plan, Do, Study, Act) process for making improvements and the benefits to the patient and the system.
- **Hand Hygiene:** Canterbury DHB has for the sixth consecutive audit period sustained the 80% hand hygiene target with an 80.8% result for the audit period 1 July – 31 October 2018 as we spread audit across the organisation.



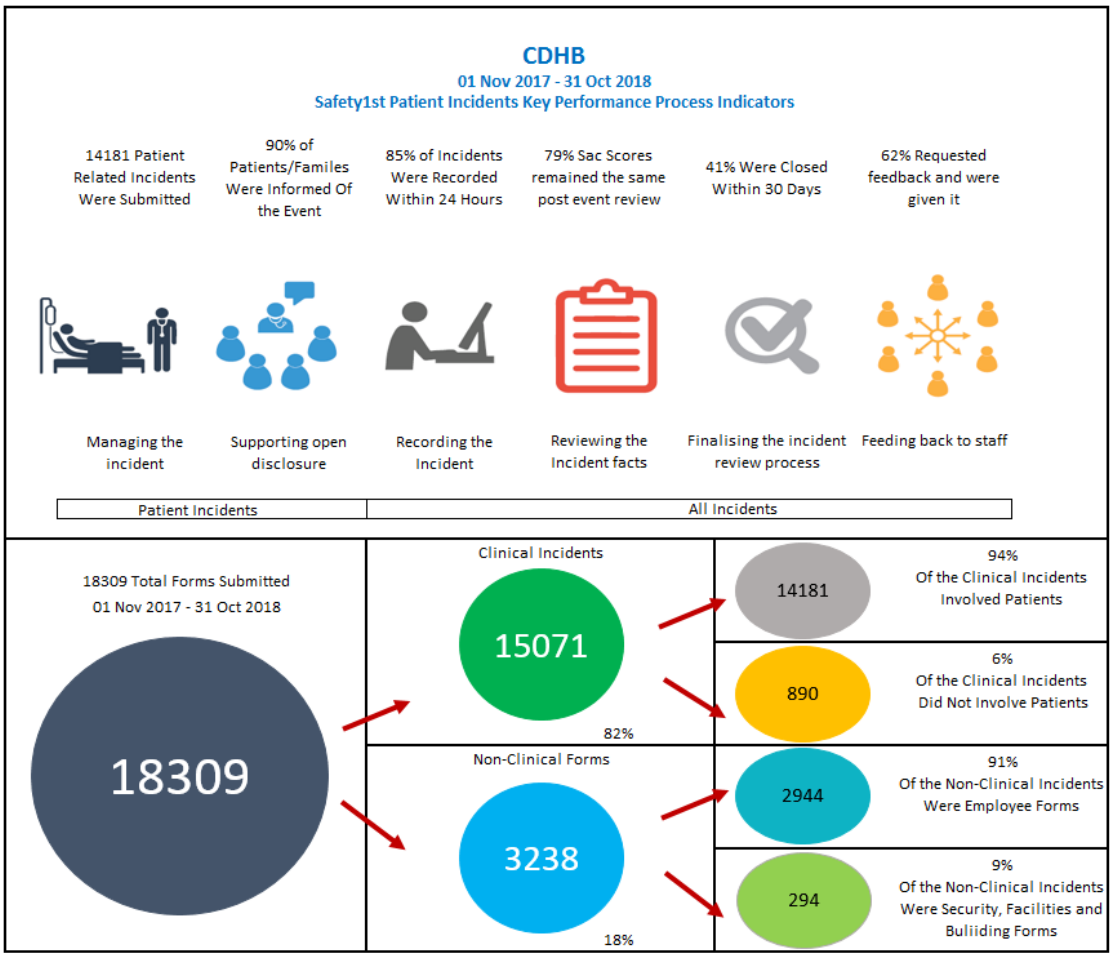
- For this period a further four wards (bringing the number to 39) were included in the Hand Hygiene National Programme.



- The remaining four inpatients areas will come on in the next audit period: Ashburton Hospital; Maternity, Christchurch Hospital; Wards 27 & 28 and Burwood Hospital; Ward C1. These wards have all been provided with resources and have been working towards inclusion in the National Programme with recent local audit activity. Consultation for monitoring of Hand Hygiene activity in Specialist Mental Health Service and Rural Hospitals is occurring.
- **Patient Safety week:** This year's Patient Safety Week (PSW 2018) was held between the 4 and 10 November.

- The topic was Infection Prevention and Control with a focus on hand hygiene. Hand hygiene helps stop the spread of germs and antibiotic-resistant infections. Using fewer antibiotics not only lessens the need for antibiotics but also reduces the opportunity for microorganisms to develop resistance and share resistance genes. The Health Quality and Safety Commission produced some colourful and engaging graphics to help us get the message across.
- **ICNet:** Canterbury DHB is taking a lead role in supporting the ACC funded project to increase uptake of ICNet, the infection prevention software that makes surveillance of organisms, and antibiotic stewardship possible and visible to the NZ. The seven remaining NZ laboratories are being supported by ACC to provide data into the Canterbury DHB instance and the first region - Midland - is preparing their business cases to purchase the software licenses. Canterbury DHB is providing the service hub (clinical and technical support) that will enable the Infection Prevention Teams learn and take the application to get the benefits.
- **Quality Accounts:** The WellNow Quality Account edition has been distributed to every mailbox in Canterbury during the first week of November. The national requirement for Quality Accounts involve health care providers demonstrating their commitment to management by fact, with continuous evidence based quality improvement. The online-only version on the Canterbury DHB website has an additional section that charts our performance against national health targets, quality and safety markers as set by the Health Quality and Safety Commission and other key measures.
- **Incident Management Process Indicators:** A new method to provide feedback to the submitter of the incident is being tested. The planned December software upgrade is inclusive

of this function which will make it mandatory for file managers to provide written feedback to the submitter from within the incident recording system.



- **Releasing Time2Care:** RT2C has developed a sustainability plan for the Canterbury DHB, this includes connecting the different projects and people to keep the patient in the centre of our care.
- *RT2C trends*
  - Direct care time for an RN remains at an average of 30 – 40% of an 8 hour shift.
  - The number of times an RN is interrupted on an 8 hour shift has decreased significantly from 160 to an average of 20.
  - Patient response to knowing what is happening today and if applicable tomorrow has remained stable between 70 – 90%.
  - Staff response to recommending their workplace as a good place to work has also remained high at an average of 70 – 90%.
- *E-handover:* An e-handover process for patients who transfer between areas internally and externally has been developed by a Canterbury DHB RT2C Working group. This process has been rolled out successfully from AMAU (November 2017) and SARA (April 2018) to receiving wards. In July 2018 this expanded to include patient transfers between Christchurch, Burwood and Ashburton Hospitals. Work is occurring to expand this process between all facilities using HCS, ICU transfers and transfers from outpatient to inpatient settings.

- *Bed Side Boards:* Now up in all areas of Burwood, Ashburton, Christchurch Women's' Hospitals, Rural hospitals and the Rural Maternity units. Audits show an increasing compliance. The model for the new Hagley building is being finalised.

- **Restorative Care at Canterbury DHB:** On 1 November, the launch for Christchurch Hospital took place**.** A restorative approach to health respects the individual' autonomy and supports them to obtain and maintain their highest level of function. There are many opportunities to provide restorative care throughout the patient journey. Strategies to support a restorative approach include:

  - Supporting patients to make informed decisions about their care
  - Encouraging whanau to be involved in the patient journey
  - Supporting emotional and cultural needs
  - Ensuring hearing and vision devices are used to support communication
  - Supporting orientation through conversation and environment set-up
  - Education on balancing rest and activity
  - Enabling appropriate footwear and clothing is worn
  - Walking with a patient to the toilet when safe to do so
  - Utilising appropriate equipment to enable patient independence
  - Checking if a patient is hydrated
  - Encouraging a patient to sit up in a chair for all meals
  - Monitoring pain levels
  - Early identification and management for potential infection
  - Monitoring and managing for constipation.

- These interventions, and others like them, are proven to reduce time spent in hospital, and to reduce problems associated with deconditioning and loss of physical and mental function. Through drawing up an individual care plan for every patient, our clinicians will make sure patients are able to keep active during hospital stays. They will aim to get patients home as soon as they are medically well enough to do so, and will enable access to community-based support to continue this restorative process once a patient is back at home.

Christchurch Campus

- **Supporting access to midwifery services over the Christmas period:** Each year a number of women are unable to secure the services of a Lead Maternity Carer midwife for births expected to happen during December or January because this is a period when more midwives are keen to take some time off than at other times during the year.

- During December 2018 and January 2019 Canterbury District Health Board will provide the same support as last year to ensure that women can access safe midwifery services. This has involved ensuring that the Midwifery Resource Centre had sufficient capacity earlier this year to be the first point of contact for women unable to find a midwife between November and February. Last year, the Centre was successful at allocating midwife capacity to over half of the group more than 140 women who needed assistance to book with a midwife.

- This year they have again done an outstanding job to allocate over 100 women to Lead Maternity Carers for antenatal care, the team at Women's will then take over ensuring that women continue to be able to locate a midwife to care for them as they get closer to term or

even when they are in labour through a phone system fondly called the festive phone at Women's.

- Our objective will remain that women who are well and do not require the tertiary services at Christchurch Women's Hospital are provided with their care in an appropriate environment. In order to achieve this all midwives have once again been invited to be part of an on call group messaging system for the women who have not been able to secure a Lead Maternity Carer for labour and birth and another pool to provide postnatal care. As with last year when we trialled this there has been a great response not only from Lead Maternity Care midwives but also our own employed midwives who want the opportunity to work across their scope of practice in the community. In particular the postnatal care provided by many of these midwives is very much appreciated by women in Canterbury and means that as a District Health Board we have almost all women who are well getting most of their care from community based midwives rather than having to be directed through our antenatal clinic. This service again continues through to the end of January 2019.

Older Persons Health & Rehabilitation (OPH&R)

- Special Falls focus meeting held with Charge Nurse Managers and Clinical managers to discuss what is happening and how to improve with an action plan being put in place as an outcome of the meeting. Key to ensuring visibility and focus by all clinical teams on reducing the harm from falls, led by the Chief of Service and Clinical Director for Older Persons Health.
- Pressure Injuries forms part of the intentional ward rounds. The plan is to ask patients about their positioning and levels of comfort, it is hoped that an output of this planned approach will see a reduction in pressure injuries. Initial indications are that this is having an impact.

IMPROVING FLOW IN OUR HOSPITALS

Christchurch Campus

- **Maternity Services encouraging use of community maternity units**: As previously reported in August 2018, maternity services are provided from a number of facilities throughout Canterbury. Information is provided to women and midwives describing the facilities available to ensure that women receive good information to support their choice of an appropriate birthing site. In August we had noted that a walkthrough video tour of the Rangiora facility was available. This has now been joined by a video showing the Lincoln Maternity facility and one featuring two new mothers telling about the reasons they chose to give birth at this facility.

Older Persons Health & Rehabilitation (OPH&R)

- **Winter planning** continues across all of the inpatients areas. The additional resources allocated to the Older Persons Health Wards has assisted in ensuring that there has been good flow from Christchurch Hospital to our Rehabilitation Wards during this winter period. We are undertaking a review of the winter flow with Christchurch Campus and Acute Demand Service Level Alliance. This will then feed into what we could do better for Winter 2019.
- Adding a "what's happening today" component after the staffing meeting at Burwood. This is focusing on patient flow and other issues, eg InterRai assessments. We are also ensuring Allied health rep attends the meeting so they can share any info which may impact on flow for home visits and discharge planning
- Collation of any variance to the previous days Expected Date Discharge (EDD) and reasons why these were not achieved eg clinical changes in patient. These will be reviewed three times a day to see what is happening in the ward environment.
- **Enhanced Recovery After Surgery (ERAS**): Overall trend for both Elective Hips and Knees seeing improvement in the percentage of patients discharged within the target of three nights/four days. Improving consistency is being evaluated against the balancing metric of readmissions which has narrowed demonstrating further consistency in our approach.

REDUCING THE TIME PEOPLE SPEND WAITING

Christchurch Campus

- **Faster Cancer Treatment Targets: 62 Day Target:** For the 3 months of July, August and September 2018 Canterbury DHB submitted 176 records to the Ministry with 32 missing the 62 days target. Of these 24 missed the target through patient choice or clinical reasons meaning eight of the remaining 152 patients missed the target due to capacity or scheduling issues. Canterbury DHB once again met the target of having at least 90% of patients receive their first treatment within 62 days of referral with 94.7 % of eligible patients being treated within 62 days.
- **31 Day Performance Measure:** Canterbury DHB submitted 416 records towards the 31 day measure in the same 3-month period. Unlike the 62 days target all reasons for missing the target are included: there are no exceptions made for patient choice or clinical considerations but the threshold remains at 85%. 377 eligible patients (0.6%) received their first treatment within 31 days from a decision to treat, meeting the 85% target.
- **Improved radiation therapy technique for breast cancer:** Volumetric Modulated Arc Therapy has been implemented for patients being treated for breast cancer. It has had significant benefits.
  - Saving patient time and minimising the time spent in an uncomfortable treatment position.
- **Supporting physical exercise in patients being treated for cancer:** The benefits that most people can achieve from regular physical exercise are well recognised. Recent media interest has publicised the growing evidence supporting the value of supporting patients being treated for cancer to get involved in physical exercise.
- Evidence of the value this provides, its limitations and areas where caution must be applied has grown rapidly in recent years. A physiotherapist based in Ward 26 and the Bone Marrow Treatment Unit at Christchurch Hospital who focusses on supporting patients with cancer recently attended the first International Conference on Physical Therapy in Oncology along

with colleagues from 29 other countries. Presentations at this conference provided some clarity about the optimal timing for intervention to support physical exercise in different patient groups, groups where the most benefit can be obtained and the risk associated with different types of exercise during some treatment regimes. Attending this conference has helped her to define some priorities about where to focus her attention and plan our initial approach in this area. Patients often have limited knowledge about the importance of exercise as they progress through cancer treatments and the potential benefits of preventing functional decline and therefore some inpatient admissions. This has prompted a focus on developing a new service to provide a proactive approach early in the course of treatment with breast cancer. This will be achieved through providing physiotherapist consultation at clinic appointments to provide education to patients and whānau to help put changes in place to manage the significant reduction in function that typically occurs during this course of treatment.

- Alongside this material about the value of exercise, and some useful approaches, has been added to the booklets provided to patients receiving chemotherapy and radiation therapy. A pathway and information sheets has been created for patients with haematological neoplasms. These changes will help support an improved recovery and experience for specific groups of patients and help us to explore the best approach to support our patients being treated for cancer.

- **Elective Services Performance Indicator (ESPI) Outcomes:** Latest preliminary reporting from the Ministry of Health shows that Canterbury DHB achieved a red result for elective services performance indicator two (covering first specialist assessment) at the end of September. This is the eighth month that this indicator has shown as red. 15 of the 26 services that contribute to this measure had no patients waiting longer than 120 days, five services had between one and ten and six services had more than eighteen.

- The same report shows that Canterbury DHB achieved a red result for elective services performance indicator five (covering waiting time for surgery) for the thirteenth month in a row at the end of September. Five of the 13 services that contribute to this measure had no patients waiting longer than 120 days, five services had between two and eight and three services had 17 or more patients waiting for longer than this.

- The Ministry of Health has provided Canterbury DHB with dispensation from Elective Services Performance Indicator achievement between January 2018 and June 2019 to recognise the pressures associated with facility limitations and issues associated with data transition. Canterbury DHB remains committed to working towards its goal that patients will not wait longer than 100 days for elective services they have been offered.

- **Major Information System transition at Christchurch Hospital:** The Homer Patient Management System which has been used within Christchurch Hospital for many years has been replaced over the past month. The Emergency Department has transitioned to a specific product known as EDaaG with most inpatient and outpatient administration functions now being carried out using the South Island Patient Information Care System. A more detailed update of the advantages, transition and work yet to occur will be provided in a subsequent report.

- **Transition to new Outpatients' building underway:** The transition to provision of services from the new Christchurch Hospital Outpatients' building has been underway. Outpatient services previously operating from a number of sites throughout the city have consolidated within the building. An update describing the benefits this has allowed us to create for patients and services will be provided in a future report.

- **Trauma Nurse Coordinator awarded:** Mel Evans, the Trauma Nurse Coordinator working at Christchurch Hospital has been awarded a Canterbury Road Trauma Award. In

the past these have been awarded to people who have carried out an heroic act. This year sees a change with recognising outstanding individuals involved in improving outcomes in the care people injured in road trauma cases. Mel provides exceptional work on a daily basis and is a star in Christchurch Hospital's developing trauma service. Her passion to see each patient receive the care they deserve and to improve our systems is a key component in the development and day to day running of this service.

- **Vascular Nurse recognised at the 2018 Australia and New Zealand Vascular Conference:** At the September 2018 Australia and New Zealand Vascular Conference held in Auckland, Christchurch Hospital's Vascular Nurse Specialist was recognised for her presentation on the success of the small aneurysm clinics that are held at Christchurch Hospital and how beneficial they are to patients. Along with this Jess was also presented with an award recognising individual members who identify with vascular as a career pathway and members who are "coming up through the ranks" in their local workplace.

- **Success at supporting breastfeeding in hospital:** Success at supporting breastfeeding by mothers who have given birth in our facilities is an important part of Canterbury DHB's Baby Friendly Hospital accreditation. Measures to improve breastfeeding rates require an integrated and collaborative approach from facilities, families, communities, services and government. The New Zealand Breastfeeding Alliance provides information to the Ministry of Health each year about rates of infant feeding at discharge from maternity facilities. For this, NZBA uses the Ministry of Health breastfeeding definitions and groups this information by facility type (tertiary, secondary and primary) and ethnicity.

- All units within Canterbury DHB are performing well, the report notes that the Rangiora Maternity Unit continues to maintain a high exclusive breastfeeding standard at 91%. This is on par with the national average for a primary unit. Lincoln and Ashburton have shown improvement compared with 2017 with exclusive breastfeeding rates of around 94%, well above the national average. Lincoln, Rangiora and Ashburton's continue to have very low artificial feeding rates, all around 1-2%. Of the 20 babies who went home from Kaikoura 17 did so being exclusively breastfed. Transfers to these units are well supported to maintain breastfeeding. This achievement is particularly significant as there continues to be a decline in breastfeeding rates in NZ over the last year.

- **Paperlite processes are leading to reductions in file storage costs:** The main focus of our paperlite approach is to ensure that information required to inform diagnosis and treatment of patients is readily available wherever it is required in the health system. Several services have focussed on effectively and safely running their clinics without the requirement to recall paper files by ensuring that the required clinical information is stored electronically. General Surgery and Gastroenterology are two services that have been successful in their attempts to avoid the requirement to recall paper files for their clinics. In addition both have also been successful at ensuring that as few paper forms are created as possible within their clinics.

- These changes have had the desired advantage in that clinical information is now available via Health Connect South whenever a clinician requires it. It has also had advantages in the way that health system resources are used. Previous reports have highlighted the way that General Surgery has been able to re-allocate administrative resources to manage increased volumes of work in general Surgery and other Services as time handling files has been eliminated. In addition to this significant saving are being made in the cost associated with outsourced file storage. In the twelve months to July 2016 file storage costs totalled $1,005,406. Two years later the cost was $814,838, a saving of $190,568 per year. The annual costs of recalling files, which is required both to access information and to file newly created paper records, has increased by $31, 804 to $307,419 over the same period.

- There are still many gains to be made that will reduce the cost of storage and recall of files. Discussions are ongoing with several services who run paperlite clinics but still create paper records that need filing. A major gain will be obtained once the process of gaining informed consent can be achieved electronically. Major gains will be made once Anaesthesia and Emergency Department are able to implement paperlite processes.

- **Combining delivery runs to make best use of resources:** Effective operation of Christchurch Hospital requires that different types of supplies are delivered on a timely basis to all areas of the hospital. Over time several services have put in place routine delivery runs to ensure that mail, medicines, clinical records and sterilised equipment are delivered. People from these various units circulate around the hospital, criss-crossing each-others paths, each providing an effective service. There is a risk that if we continue to work in existing ways as the campus grows in both floor area and complexity that the total time required by these tasks will increase. When viewed collectively, and with the trend towards less mail and paperlite ways of working, it is clear that we can make more efficient use of these people's time, releasing some to enable other tasks to be performed. A fresh approach, promoted by the Releasing Time To Care and an Xcelr8 project by Elaine Ryan, Vini Butcher and Rohanne Compton, will be put in place with the opening of Christchurch Hospital Outpatients' Building that combines these four delivery runs into one and standardises our approach. Mail, clinical records, pharmacy and sterile supplies will be delivered to the Outpatients' building as part of a single routine delivery run several times a day. While records and mail were previously dropped at several individual places within each department the process has been further streamlined by use of single drop off/pick up points for mail and records on each floor of the new building. These points are standardised, and swipe card secured. Existing Orderly capacity will be used to carry out this task and Pharmacy Technician Sterile Supply and Mail Room capacity that was previously required to deliver to Outpatients' areas will be freed up to carry out other tasks, often those that only those teams can carry out. Following a three month test period, during which lessons will be learned and processes improved, we will work within staff involved in these duties to consider rolling this approach out to areas within the Riverside and Parkside Buildings and then in Christchurch Hospital Hagley.

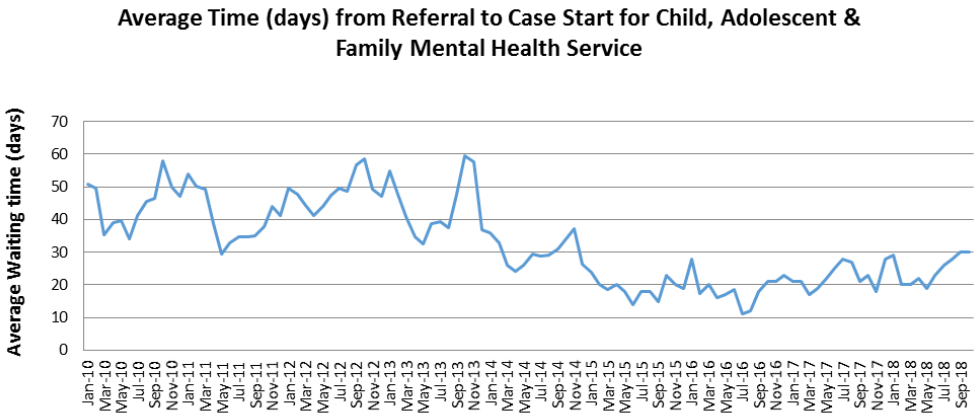
Specialist Mental Health Services (SMHS)

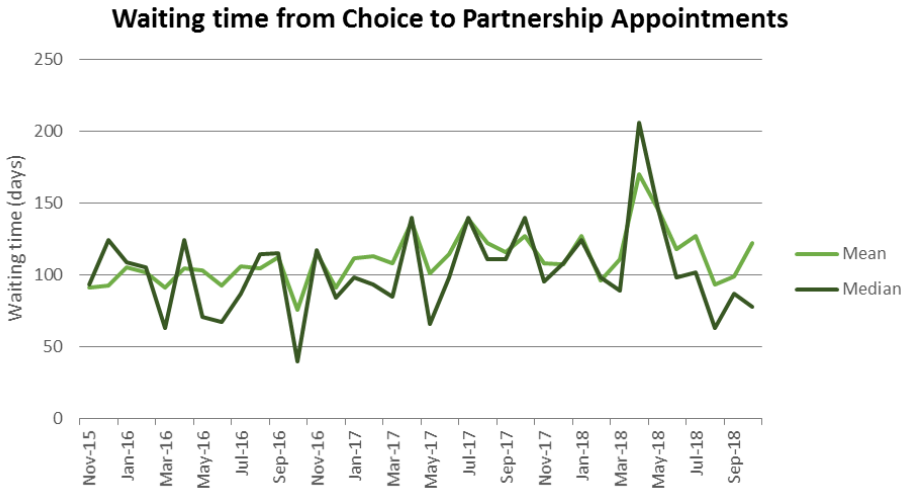
- **Demand for Specialist Mental Health Services**: We continue to closely monitor use of Mental Health Services. Our staff are working exceptionally hard to provide the best care possible in some very challenging circumstances and we are continuously looking for ways to make the environment as safe as possible for consumers and staff.

- Occupancy of the **adult acute inpatient service** was 95% in October 2018. There have been periods of extreme pressure this month when the Te Awakura unit was 100% full with further admissions pending. High occupancy is unsustainable and does not allow for increased demand over time. Our staff are doing an incredible job in very challenging circumstances. Planning and Funding are leading the development of a community service that will provide an 8 bed alternative to an acute inpatient admission which is anticipated to open early to mid-2019.

- **Demand for Adult Services** continues to be high. There were 236 new crisis case starts in October 2018. New crisis case starts require an assessment and response within a day of referral. The adult general service continues to exceed national targets with respect to wait times for adult Specialist Mental Health Services. The wait time targets are 80% of people seen within 21 days and 95% within 56 days. In October 2018, 93.1% of people referred to the Adult Community Service were seen within 21 days and 98.7% were seen within 56 days. The percentages for October 2018 were 89.7% and 96.1% respectively when other adult services, i.e. Specialty, Rehabilitation and Forensic, were included.

- **Least restrictive practice** During October seclusion hours increased due to a higher than usual number of acutely unwell consumers being admitted to Te Awakura. The use of two of the four high care areas had limited capacity to manage acutely unwell people. This was due to the high care needs of two people.
- **Child, Adolescent and Family (CAF):** Wait times for Child, Adolescent and Family services remain a concern. National targets require 80% of young people to be seen within 21 days and 95% within 56 days. Our results for October 2018 show that 57.5% of children and adolescents were seen within 21 days and 85.8% within 56 days. Child, Adolescent and Family Services had 233 new case starts in October 2018. There are ongoing challenges with reducing the wait times while at the same time continuing to receive high numbers of referrals (averaging 70 per week). We are working on improving health pathways and responsiveness to young people with Attention Deficit Hyperactivity Disorder (ADHD).





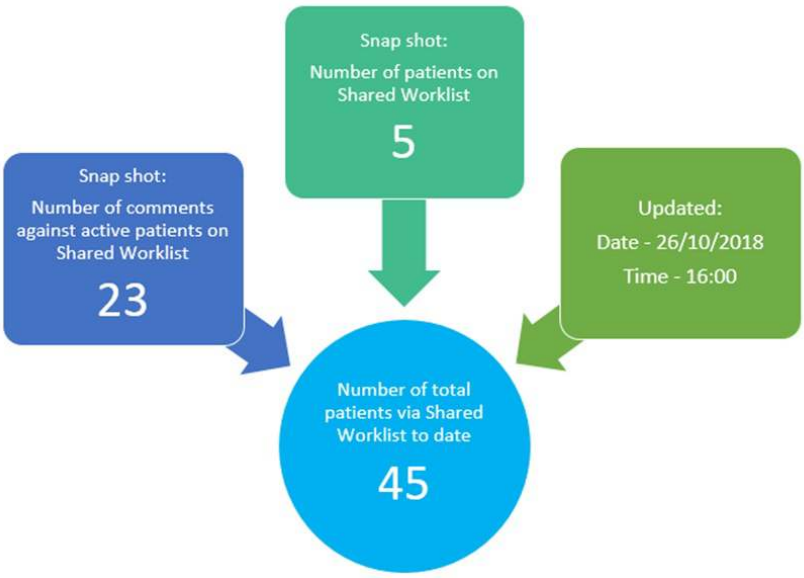
- Child, Adolescent and Family Services have applied a comprehensive approach to managing the waitlist. There have been multiple streams of clinician contact, with an increased capacity to take on new partnership appointments. This, combined with the provision of alternate treatment pathways for consumers has resulted in a marked increase in reported waiting time (as shown in the graph above) for partnership appointments.
- **Schools based Mental Health Team** continues to be approached by new schools across Canterbury requesting engagement. The team responds to each request and provides an

individualised approach for each school. The team is currently engaged with 166 schools across the region. The most recent school counsellor forum held in September 2018 focussed on working more collaboratively with school counsellors and improving communication. A small working group has since met to discuss ways to enhance the relationship and alignment across services. The team continues to attend regular pastoral care meetings in many schools, and participates in Rock On meetings at which attendance issues are discussed. Networking and fostering strong relationships across schools and with the Ministry of Education remains a major function.

- **Mana Ake** - The SBMHT are working with Mana Ake and have provided some training for new staff. They continue to be involved in the various Mana Ake Working groups and will continue to develop and build relationships with Mana Ake as the roll out continues.
- **Sparklers**, the new toolkit developed in association with the All Right? Campaign, has now been rolled out into Christchurch Intermediate schools.

Older Persons Health & Rehabilitation (OPH&R)

- **Adult Rehabilitation project:** Transition of care work stream – we have commenced the use of the Collaborate shared work lists between two wards at Christchurch Hospital and Ward CG – Brain Injury service. This is used to provide an electronic record of transfer of care discussion for patients between the two services. This ensures that there is transparency of information which can be easily updated by each service. The Clinical teams are finding it extremely useful to have the transfer information all in one place and the history of conversations maintained. We are currently assessing which additional services and areas will move onto this platform next.
- Transfer of Care meetings have also commended to support referrals on the adult rehab pathway – focusing on the complex patients. There are clinical representatives from the services based at Burwood Hospital – Older Persons Health, Brain Injury, Spinal, and other services as required to facilitate transfers to the most appropriate Ward/ Service based on the clinical requirements of the patient. This provides a point of entry into rehabilitation services and reduces the multiple referrals which have happened historically. It also provides wider Clinical support for these complex patients who often require input across multiple services.



- **Older Persons Health Inpatient Wards:** Two Wards have commenced a trial of the Purpose T Clinical Pathway. This Clinical pathway aims to enable earlier detection of

pressure risk patients and improve our management of these patients to reduce pressure injuries. The trial was successful and the pathway will be rolled out to the other Older Persons Health Wards in the coming weeks.

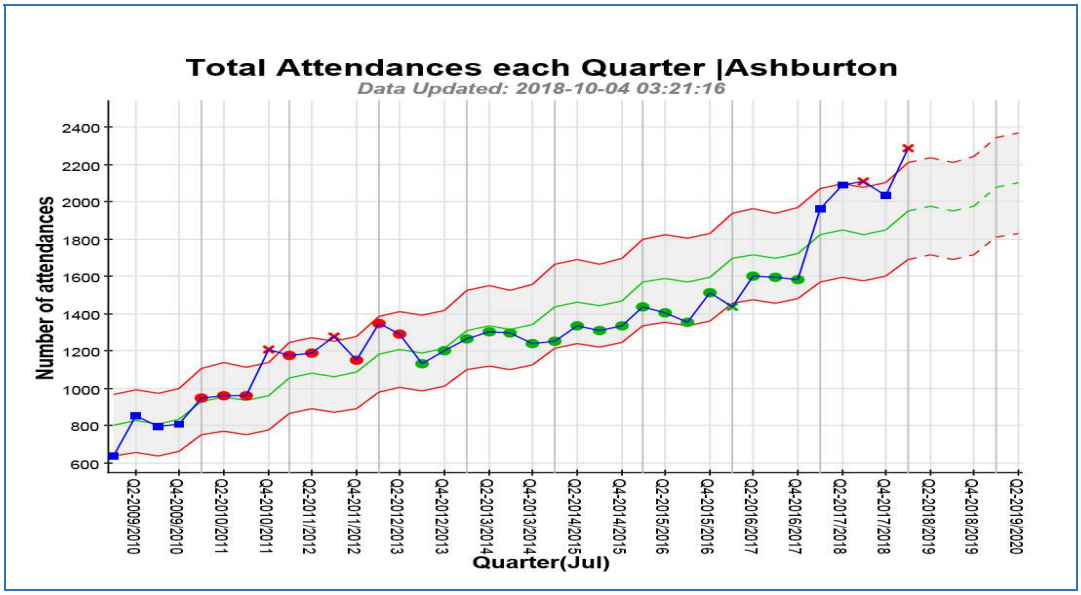
- **Outpatients:** There has been a focused piece of work on Outpatients for Older Persons Health. This has resulted in consistency of process for all patients across the service and reduced waiting times with all patients now being seen within triage category recommended timeframes
- **Community Based Rehabilitation Services:** Evolving models of care in rehabilitation in response to changes in our acute and sub-acute hospitals, have resulted in the development of community based rehabilitation services. Provision of community rehabilitation services presents a number of challenges including how to compare the effectiveness of these services and the interventions within them. In response to these challenges, the Australasian Rehabilitation Outcomes Centre (AROC) have implemented the National Ambulatory benchmarking initiative to enable the collection of outcome measures data from services in the community. The Canterbury Community Stroke Team is piloting the use of this benchmarking tool. This will allow us to evaluate the effectiveness of different models.
- **Community Dental Service** As part of national oral health day (2 November 2018) we asked everyone to swap their sugary drinks and give water a go for 30 days in November. Supported by New Zealand Pole Vaulter a significant emphasis was placed this year to increase awareness of the impact of sugar.

Ashburton Health Services

- Brenda Close has been announced as the new Director of Nursing, Ashburton and Rural, commencing on 3 December 2018. Brenda brings a wealth of knowledge and experience in nursing leadership, with an extensive career in hospitals and communities across New Zealand and Australia. Brenda has a passion for providing the highest standards of healthcare, with demonstrated track record in successfully directing models of care and nursing developments across multiple services configurations. This includes her most recent roles as Director of Nursing/Hospital and Facility Management in Rural and Remote Australia, but many may know her from her nursing leadership in New Zealand and commitment to improving health care and outcomes for Maori. As the Director of Nursing Ashburton and Rural, Brenda will be based at Ashburton Hospital but will be spending time

with the Community Rural Hospitals providing the professional direction and nursing leadership across these facilities.

Acute Care



- Ongoing engagement with primary care and our partners in the Ashburton Service Level Alliance continues as we explore solutions to manage the increasing presentations to the Acute Assessment Unit (AAU). As the above graph demonstrates, the trend continues to be well above the expected volumes. The hospital clinical and management team, working with the Ashburton Service Level Alliance (ASLA) operations group, are re-running the volumes of presentations and reasons for presentation for each of the primary care practices. Information reviewed to date has not signalled any specific cohort of presentation growing at a higher rate than others. The information is presented for discussion with the practices, informal feedback to date suggests general practice teams are wanting to ensure their patients are presenting earlier to primary care.

- In addition to the discussions connected directly with the primary care teams via General Practitioner and PHO representation, the ALSA Operations Group are focused on implementing monthly practice managers meetings to support improved communication across the health provider community in Ashburton.

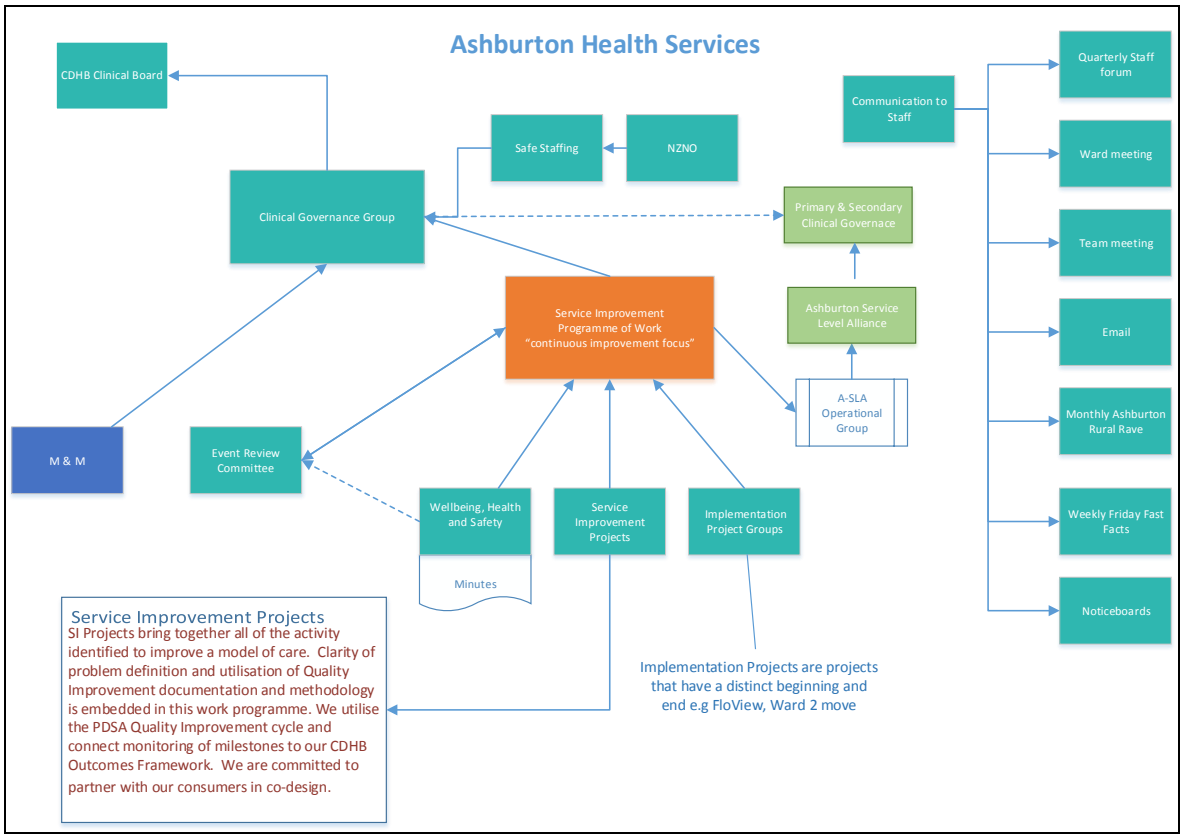
- The general practice representation of the Ashburton Service Level Alliance have also requested the establishment and implementation of a primary – secondary clinical governance group to explore system level improvements specifically between the hospital and primary care teams. The terms of reference and process are still to be worked through, primary care representation indicate a strong commitment to a vehicle such as this being the opportunity to address some of the current patient flow challenges. It was noted at the most recent meeting that the impending arrival of a new Director of Nursing for Ashburton and Rural would provide an ideal catalyst to explore how this opportunity could be bought to life.

- We are in the process of implementing a Signals from Noise report for our inpatient and primary birthing services. The implementation of SI PICS has progressed, creating some availability for our service improvement co-ordinator to refocus on this area for future reports.

- In addition to the current workgroup and localised representation committees discussing system level change, we have received ongoing feedback from primary care looking for a structured opportunity to discuss individual patient cases as an integrated system. The Senior Medical Officers (SMOs) working in Ashburton and primary care general practice

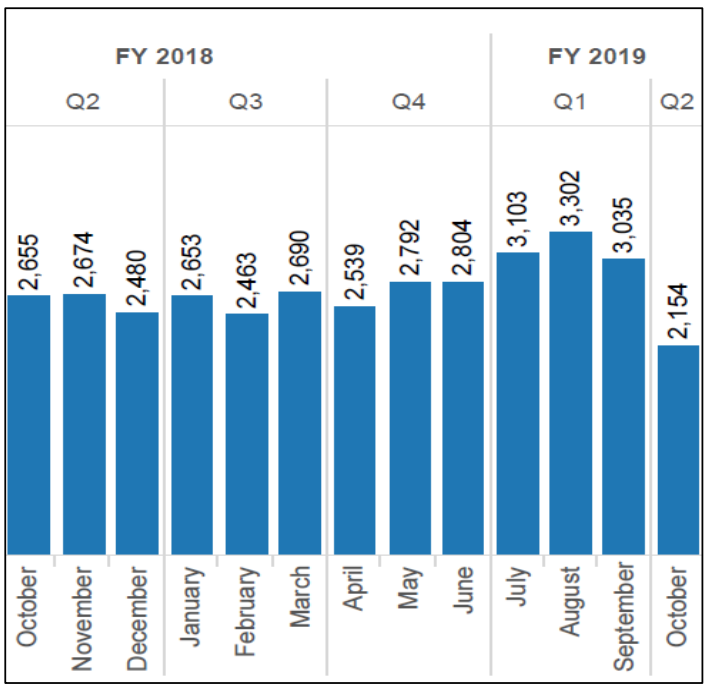
representatives are progressing options to expand the hospital mortality and morbidity (M&M) committee to include primary care. Agreed shared learnings from these reviews would be provided to the local clinical governance group to progress any opportunity for system level change.

- Many of the team working on the floor or in the community in Ashburton have expressed frustration in keeping up with implementation of new systems that are affecting them or how they can connect into developing new ways of working across the hospital and other service providers. As a smaller team, with some local services managed centrally via Christchurch, we are mindful that need to keep people connected to what we are changing and why. A key observation locally from our work to date with our Releasing Time to Care colleagues, is our opportunity to improve our understanding and communication of "the problem we are aiming to address". The team is often enthusiastic to lead positive improvements for patients and staff, but without a visible approach to the work underway and impact on other services has led to some frustration and unintended consequences. To support success in our collective programme of work, we have bought together the following diagram for our local team and partners in the SLA in an attempt to demonstrate where we connect and remind ourselves of the importance of connecting and communicating.
- The Event Review Committee brings together employee and patient safety events that clinical and management leadership have identified as requiring a wider MDT discussion. This group receives the trends reports from Safety First for both areas. In addition this group is provided with a "patient voice report". This report consolidates the information from our patient survey (inpatient and outpatients) and trends reports on complaints received. Most recently the group have requested further detail on safety first reports identify an incident relating to the provision of care. This has moved away from events pertaining to staffing ratios. A staff are becoming more comfortable with reporting events this data is becoming a rich source of "early signals" of areas where a quality improvement project could be established.
- The Service Improvement Programme of work will be a published document for all staff, identifying all projects underway, who is involved, intended outcomes and timelines. This will be completed in time to align with the implementation of PRISM and the new look intranet and sharepoint upgrade across CDHB, providing all stakeholders in CDHB visibility of the work underway in Ashburton. This will enable us to provide a clear indication to the Board on our work underway, its intended achievements (mapped to CDHB priorities) and progress against these.



INTEGRATING THE CANTERBURY HEALTH SYSTEM

Acute Demand Management



- The transition to South Island PICS has resulted in transition to a new ED patient management system, ED at a glance (EDaaG). The new system has been well accepted however data feeds are still being re-established. The winter peak has passed but volumes remain steady. The process of developing new strategies for winter next year has begun with the aim of addressing a deficit of 60 beds (accounting for the increased population).

ED Attendances per month

SUPPORTING OUR VULNERABLE POPULATIONS

Older Persons' Health

- **HealthONE in Aged Residential Care facilities:** We have progressed into the first stage of rolling HealthOne out into Aged Residential Care facilities. Ryman Healthcare is in the process of setting up the required secure connections to HealthOne. Once this has been completed, virtual testing will be progressing in mid-December. This work will provide those working in residential care the same access to the clinical records of their residents as others across the health system, enabling better communication, more informed wrap-around services, safer and more efficient transfers of care, and clarity around individuals' diagnoses, pharmaceutical requirements, and restorative goals.

Mental Health

- **Additional Mental Health Services:** Discussions with the Ministry of Health will soon commence regarding the future of the additional funding in place to support additional mental health services. The 2016 contract is due to end in mid-2019. Regardless of the outcome of these discussions, the current service configuration will be reviewed to ensure resources are responding to highest need areas.

- **Canterbury Addiction Services**

Primary substance	Referrals in quarter one 2017/18	Referrals in quarter one 2018/19
Alcohol	312	313
Cannabis	72	79
Methamphetamine	60	72
Opioids	55	64
Synthetics	19	35
Benzodiazepines	6	9
MDMA	1	3
Ritalin	7	3
Unspecified	12	15
Gambling	1	1
TOTAL	545	594

The centralised pathway for people with alcohol and other drug challenges continues to work well.

Despite the low numbers of people presenting for help with synthetic use, there is work occurring to develop an immediate response if a 'bad batch' situation occurs again in the future.

This is focused on early detection and getting accurate safety information to the community, particularly to high risk groups who are unlikely to access usual media outlets.

- **Mana Ake – Stronger for Tomorrow:** Phase 3 kaimahi (workers) were welcomed at the start of October for a two week induction supported by a range of stakeholders. The kaimahi commenced in schools on 15 October bringing the total number of schools to 98 and the total number of kaimahi to 40.

- Two team leaders are now on board with recruitment underway for an additional six. The term Team Leader will be changed to Cluster Lead, to more accurately reflect the purpose of the role.

- We are in the process of appointing an Evaluation Lead to whose role it will be to refine and implement the evaluation approach for Mana Ake.

- The project team sits under the Canterbury Clinical Network comprising of the Project Lead, Implementation Lead, Practice Lead and Evaluation Lead. The Implementation Lead, Practice Lead and Evaluation Lead are 18 month fixed term positions whilst we clarify the level of ongoing support needed to support longer term implementation.
- By the end of 31 October 283 requests for support have been received and 229 remain active

Primary Care

- **Primary Health Services:** Canterbury's three PHOs have been working with their general practices to inform implementation of the Government's new initiatives beginning in December. These initiatives are to lower the cost of primary healthcare for children under 14 and people holding a Community Services Card (CSC). Implementing these initiatives is voluntary however we expect all practices will implement the 'Free for Under 14s' initiative as it is a simple extension of an existing policy. Initial take-up of the CSC initiative is less certain with some practices concerned about its impact on patient demand on their capacity, and an additional restraint on their freedom to set fees. We will know initial take-up by 15 November when PHOs must inform DHBs and the Ministry.
- With PHOs and key urgent care clinics, we are addressing the funding of free access to urgent care after-hours for children under 14. We're aiming to provide this access in a way that does not undermine the continuity of care that general practices provide for families during regular clinic hours.
- **Pharmacy Services:** The Government's 'Free for Under 14s' initiative also extends to pharmacy services. From 1 December prescriptions for children under 14 will have no co-payment (usually $5). We will also extend existing 'Free for Under 13s' arrangements with pharmacies associated with key urgent care clinics to ensure, for children under 14, prescriptions dispensed after-hours are free of any after-hours fee which other patients pay in some circumstances .

Promotion of Healthy Environments & Lifestyles

- ***All Right?* social marketing campaign update:** The *All Right?* campaign team is committed to sharing information about what has been learned from running a social marketing health promotion campaign. To that end, the team is in the final stages of submitting an article to the International Journal of Health Promotion on the evaluation of the usefulness and impact of the Campaign's Facebook page particularly in a disaster recovery situation, as well as promoting mental wellbeing generally. The *All Right?* campaign team is presenting a poster at the Earthquake Recovery Symposium in November about the reach and impact of the campaign. In addition, a poster about the Sparklers initiative has been prepared for the Canterbury DHB's Quality Awards. The *All Right?* campaign team has submitted several abstracts to the International Union for Health Promotion and Education (IUHPE) 23rd world conference taking place in Rotorua in April 2019, and is in the process of submitting an abstract to the International Positive Psychology conference being held in Melbourne in 2019.
- **Health Notification alert level agreed with Fire and Emergency New Zealand:** Following the Ravensdown fire which highlighted a communication issue between Fire and Emergency New Zealand (FENZ) and Community and Public Health, staff have been in contact with FENZ to agree a Health notification alert level. Further to this, staff from Community and Public Health met with representatives of FENZ to discuss the role of Health and to progress the alert level definition. The need for the establishment of a HazMat Co-ordination Committee was highlighted. Other important actions that resulted from this meeting are as follows:

- At the next leaders' briefing, the issue of alerting Health Protection Officers (HPOs) will be raised and leaders will be encouraged to consider contacting HPOs when there is a potential risk of smoke contamination, groundwater contamination, asbestos contamination or contamination caused by other hazardous materials.
- A new database EMCOP will be piloted during December 2018 which if successful, will be rolled out next year allowing all associated agencies (including Public Health) access to critical information quickly and easily.

- **Wairewa Health Hui:** As a result of Te Hapu O Ngati Wheke Health Hui in June 2018, the general consensus of the fourteen strong members of the Health Collective who participated was to involve other marae. Wairewa was chosen as the next venue. The local community was consulted and expressed an interest in having a nurse-led clinic for both Little River and Birdlings Flat, or alternatively to have a regular service providing basic health checks. There was also good feedback from the Collective who plan to stay together and revisit the question of a service to Wairewa/Birdlings Flat at a later date.

- **Lyttleton Health Hub:** The Lyttleton Health Hub was established following Te Hapu O Ngati Wheke Hui in June 2018. The idea of a Health Hub for Lyttleton was proposed and introduced to the Lyttleton Health and Wellness Vision group by a health promoter from Community and Public Health. A General Practitioner who owns the local Health Centre was keen to help out and has offered her practice to the Health Collective for their use on the first Saturday of every month. Two hours monthly of free access will be offered to the local community throughout 2019.

- **Health Promoting Schools (HPS):** The second of the biannual Primary School Health and Wellbeing Leadership Forums for the year was again hosted by Wharenui School's HPS leadership team, on 20 September 2018. Over 100 students from 11 schools attended. A group of four secondary students from Marian College also observed and supported the running of the forum with a view to developing a similar forum across the schools involved in the Catholic Kāhui Ako. During the forum student groups from each school offered progress reports on the health promotion projects they have been working on.

- Students, staff and parents in attendance interacted with health and wellbeing stations including oral health (run by two schools), heart health (Heart Foundation), fire safety (Fire and Emergency NZ), safe and caring communities (Neighbourhood Support), looking after our environment (Keep Christchurch Beautiful and CCC Graffiti Project), asthma (Can Breathe), Smokefree (CPH Health Promoter), and mental wellbeing (School Based Mental Health Team). Links were made and ideas generated for further collaborative health promoting activities in the attending schools.

- The Forum embodies the importance of cultural identity to wellbeing. Recognising the cultural diversity represented, the morning was closed by the Wharenui School Pacific Nations Group singing their beautiful version of the Fijian song Isa Lei.

- **Tertiary South Island 'Drugs on Campus' workshop:** A South Island 'Drugs on Campus' workshop was organised by CPH's tertiary health promoter in response to drug issues identified at campus events. The workshop led by the New Zealand Drug Foundation (Wellington) and Community Action on Drugs and Youth (CAYAD), was attended by about 40 people from the University of Otago, the Southern Institute of Technology, the University

of Canterbury, Ara, Lincoln University, the Nelson-Marlborough Institute of Technology, and by video link to Tai Poutini. Excellent feedback was received from participants, who are currently planning for safer orientation events for the 2019 academic year.

- **Update on recent housing submissions:** Housing quality and security are known determinants of health, particularly for vulnerable populations, such as children and older people, Māori and Pacific peoples, and those living with disabilities and mental illness. The Canterbury DHB recently prepared two submissions in response to recent consultations by the Ministry for Building, Innovation and Employment (MBIE): a discussion document outlining proposed reforms of the Residential Tenancies Act (RTA) 1986 and the proposed Healthy Homes Standards for rental properties, which are the regulations of the Healthy Homes Guarantee Act 2017. The reform of the RTA provides an opportunity to improve conditions for the growing number of people who rent. The Canterbury DHB recommendations focused on how the reforms can improve security of tenure for renters by making period tenancies the norm, limiting the reasons that landlords can evict tenants, and increasing the notice period for landlords so that tenants have more time to secure new housing and leave their existing rental property.

- The proposed Healthy Homes Standards for rental properties include indoor temperature standards, heating requirements, insulation, ventilation, moisture ingress, draught stopping, and drainage, as well as the details of implementation and compliance with the standards. The Canterbury DHB submission provided feedback on several proposed options across all of these areas with the objective of ensuring that the Standards encourage the provision of high quality rental homes that support positive health outcomes, primarily addressing the factors that lead to cold and damp homes. The recommendations in both submissions could have substantive benefits for tenants' health and wellbeing and help address the health inequities of those who rent.

- Community and Public Health also hosted a Healthy Christchurch lunchtime seminar during the consultation period to provide information about the legislation and why it matters, together with perspectives from people working in relevant areas, including Anglican Advocacy, the Christchurch City Council, and Tenants Protection Association. Attendees at the seminar were able to record their thoughts directly in submissions to MBIE.

- **Safe use of compost and potting mix – use the five steps to reduce your risk:** Members of the Communicable Diseases Team at Community and Public Health have been busy implementing a publicity plan to promote the safe use of compost and potting mix ahead of the spring garden rush – particularly in the lead up to Show Weekend. This has involved using a range of media formats together with the provision of resources to local A&P Show organisers, highlighting the serious illness that can follow when someone becomes ill due to handling compost/potting mix as well as the cost to the health system. Those handling compost/potting mix are encouraged to follow the five steps presented below to avoid acquiring Legionnaires' disease.

SUPPORTING OUR TRANSFORMATION

Effective Information Systems

- **Projects, including facilities and redevelopment**
  - **Acute Services Building:** Some permanent switches have been installed on Levels 3 and 4 which is sufficient to commission items such as Nurse Call, BMS, Emergency Lighting, Access Control and CCTV. The commissioning of access card system is in progress.
  - **Christchurch Outpatients:** Network patching has been completed and the paging interface to a fixed duress system is operational. The majority of telephones are in place, and the installation is complete at all levels for the AV Meeting Rooms. Staff were on site during the first weekend move to complete connections.
- **Digital Transformation**
  - **Cardiac Test Repository:** Pilot in development
  - **End of Bed Chart (Clinical Cockpit):** Project to collate information from a number of systems on a hand-held device, including Medchart, Patientrack and Éclair results. Preferred vendor selected, and the Business case is in progress.
  - **Cortex:** Digital progress notes across Nursing, Allied Health and Doctors which will be accessible from point-of-care devices (iPads) so that the care team has immediate access to accurate information about our patients. The Business Case is currently in development.
  - **Health Connect South:** Support agreements with the regional DHB's have been drafted through following the signing of the South Island Strategic Partnership Agreement (SISPA) with Orion. There is a renewed focus on accelerating the on-boarding of additional organisations with HealthONE.
  - **South Island Patient Information Care System (SIPICS):** Christchurch Campus and Ashburton hospital went live on 6 October 2018. This was followed by the parallel implementation of the Emergency Department at a Glance (EDaaG) system going live on 17 October 2018. Planning is underway to migrate the maternity services system.
  - The rollout of SI PICS to Christchurch Hospital Campus and Ashburton Hospital is a significant achievement, replacing the primary use of three outdated software systems in Canterbury, with two of them being more than 20 years old. More than one million patient records were successfully transferred into the new patient management system.
  - As expected there are a number of transition issues that need to be worked through. Some are related to software functionality and will be improved with the programmed upgrades and some are more about people learning to use new software. There remains some issues with data quality and reporting capability and a team has been established to focus on these areas.
  - This is one of the largest health software programmes undertaken in New Zealand – certainly in the past decade. SI PICS works in conjunction with the existing South Island-wide clinical portal Health Connect South and is a step closer to the vision of a fully integrated electronic patient record.

Integrated Family Health Services and Community Health Hubs

- Improving access and closer integration of health services is being pursued in several rural areas.

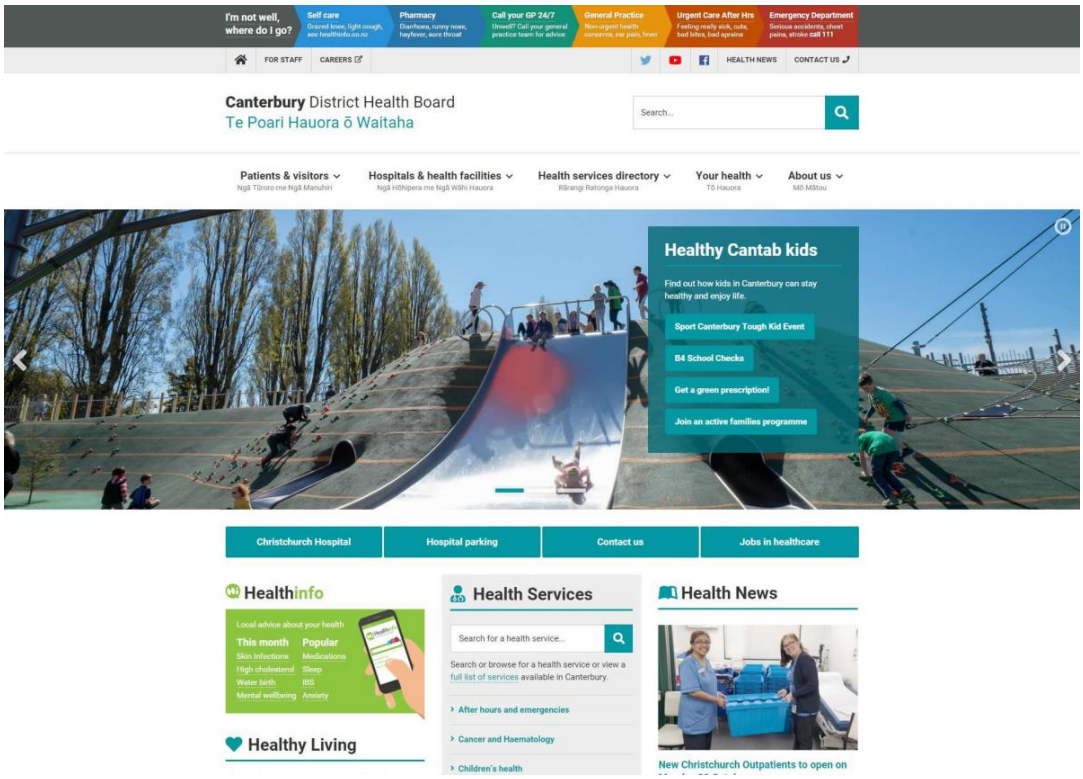
- **Hurunui –** implementing recommended changes endorsed by the Board at its meeting in July is underway. A six month trial of new urgent care after-hours arrangements has begun, with local practices sharing clinical workforce, monitoring case-load and regularly reviewing responses to individual cases. In addition Hanmer Springs Health Centre now has lead responsibility for providing access to urgent care after-hours for communities of the northern Hurunui.
- **Oxford –** The Oxford and Surrounding Area Health Services Development Group continues to develop recommendations for improve local access to health services. Key areas of focus are: transport for access to health services in Christchurch; telehealth for local access to specialist clinics; urgent care after-hours; and restorative care in the community for people following hospital discharge. The Group is now reviewing feedback from the community on its draft recommendations.

COMMUNICATION AND STAKEHOLDER ENGAGEMENT

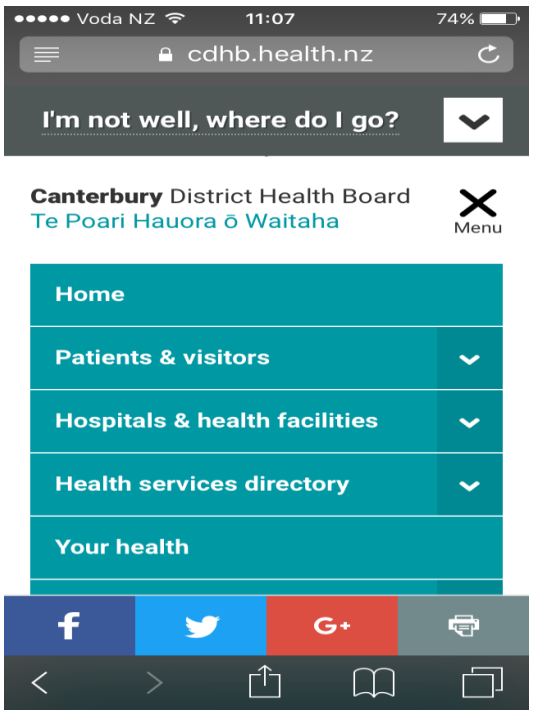
Communications and Engagement

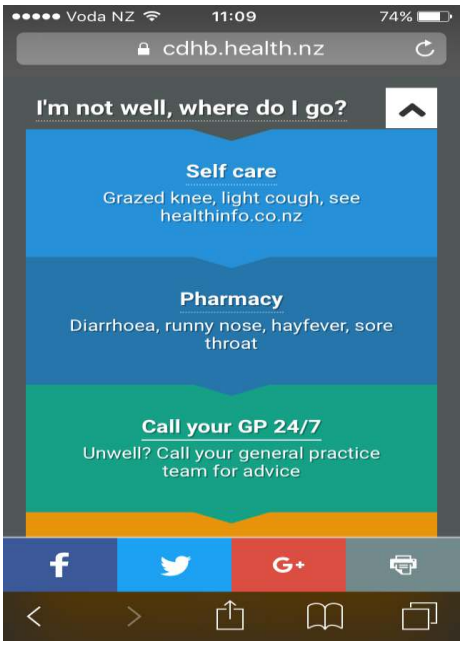
- **Website Redevelopment:** Responsive mobile websites for Canterbury DHB and West Coast DHB were 'soft-launched' at the same time on 19 October 2018. These newly designed public websites use a flexible WordPress infrastructure, and are intended to meet the needs of the general public, providing information about health system activities and how to use health services in Canterbury. The new infrastructure provides a base for further improvements during 2019 when much of our public information is planned to be enhanced so that it is more usable and accessible for people, particularly for people with a disability. Although this is the first step for the new websites and there is much to be improved, with features built so that they are specifically aligned with many of our key health outcomes.

New Canterbury District Health Board Home Page



Mobile Images





- **Water expo, Christchurch City Council, Thursday 18 October:** Christchurch City Council hosted a Water Expo for Council, Canterbury DHB and Environment Canterbury staff in the Function Room at Te Hononga Civic Offices. The event was held to raise awareness and educate people about why the Council is chlorinating, improvements to the network and what's in the pipeline for the Canterbury region's water. Alistair Humphrey and Judy Williamson from Community and Public Health attended as Canterbury DHB experts to answer questions about water, chlorination and health. The expo will be evaluated and potentially adapted for a public audience in the future.

- **Pressure Injury Prevention Link Nurses:** Media were invited to a photo opportunity with ACC, Canterbury DHB's Quality team and representatives from Canterbury DHB's first group of Pressure Injury Prevention Link Nurses. The nurses have been appointed as part of a broader strategy funded by the ACC to reduce the incidence and severity of pressure injuries across Canterbury and the West Coast. Media coverage included Hokitika Guardian, HealthCentral, NewstalkZB. An article will also appear in the November issue of NZNO's journal Kai Tiaki.

Mary Gordon with ACC Senior Injury Prevention Specialist Sean Bridge, ACC Treatment Safety Manager Dr Nick Kendal and Susan Wood

- The Quality Accounts edition of WellNow Canterbury, our community magazine was delivered throughout Canterbury and the Chatham Islands from 12 November. A more detailed on-line version has been live at cdhb.health.nz from 5 November. The on-line version provides more detailed performance data, while the printed magazine focuses on patient stories.

Media

- During October synthetic cannabis continued to be the most dominant topic of media enquiries, with specific admission numbers consistently being requested. In response to these we reiterated that the rate of presentation remained at 1-2 per day, other than the initial spike which prompted our media release warning on 20 September and our media stand-up on 21 September. Communication has worked with the Specialist Mental Health Services team to create an information pack on synthetic cannabinoids which have been designed and provided to Service Managers for distribution to families.
- Some of the other topics of media interest included:
  - Lime Scooter injuries
  - The move to the new Outpatients building/new technology
  - Annual Report/Budget details
  - Toilet training and paediatric continence
  - Mental Health funding and staff turnover
  - AT&R Unit
  - Relocation of specialist mental health services
  - Child, adolescent and family wait times
  - Acute Services Building progress & pipes

- The Press interviewed Rebecca Stark, Clinical Director of Ophthalmology, about what the move into the new Outpatients building meant for the eye clinic, its services and how it will improve the treatment staff can provide to patients. Dr Rob Ojala, Clinical Lead for Facilities Management, was also interviewed about the new facilities and the journey to get to the point where services are now operating from the new building.
- E-health news interviewed Stella Ward, Chief Digital Officer and Executive Lead for Innovation, about the new state-of-the-art technology facilities being used in the Manawa Campus.
- Live radio interviews – Canterbury Mornings with Chris Lynch featured:
  - Dr Ramon Pink, Medial Officer of Health, on Legionnaires and what to look out for as we move into the gardening season.
  - Karaitiana Tickell, Chief Executive Officer Purapura Whetu Trust, provided an update on Mana Ake.
  - Heather Bushaway, Canterbury DHB Falls Champion and Rebecca Logan, Sport Canterbury, on the Falls and Fractures Service Level Alliance.

Facilities Redevelopment

- **Christchurch Outpatients**
  - A building blessing service was held on 5 October, with around 150 people in attendance including the CEO and Chair of the DHB. The service was run by kaumatua Rev Maurice Gray with support from the Maori Health team and the chaplains.
  - Two staff open days in the same week were well attended by 550 staff.
  - Weekly videos and info-sheets were produced for staff ahead of the moves into the building in late October. The videos covered all the topics that staff needed to know ahead of the move and feature GM Pauline Clark introducing each one. This work has included communicating the new systems for centralised deliveries of mail, records, pharmacy, linen etc, and the correct defect reporting process. The content has been shared across facebook groups, TV screens in the Great Escape, the weekly CEO update and direct email.
  - New parking information has been distributed to staff to communicate the best ways for patients to get to appointments.
  - We are still working with Christchurch City Council and Otakaro on producing information about access to the Outpatients building once Oxford Terrace is open. The expected opening date has been pushed back by Otakaro to 18 December.
  - We have fielded a steady stream of staff questions about the move.
  - The on-line building handbook has been updated regularly.
- **Acute Services building**
  - Work is ongoing communicating site activity related to the Acute Services build, mostly via the daily global and weekly CEO updates.
- **CEO Update stories**
  - Canterbury DHB was the only district health board in the country in the last quarter of 2017/18 to achieve the target of 95 percent of eight month olds having their primary course of immunisation (six weeks, three months and five months immunisation events) on time. It was a huge task to reach those last few families and one that couldn't have been done without the combined effort and passionate determination of Canterbury's Missed Events Service team, the National Immunisation Register team, the Outreach Nurses Service, the Immunisation Co-ordinators and General Practice. The focus was

on four babies on the Canterbury DHB National Immunisation Register who were gone with no forwarding address. By the end of the quarter, after much effort, three of them had been located and vaccinated. In the days and hours leading up to the babies hitting their milestone age Canterbury DHB Missed Events Coordinator Sally Wright was in constant contact with the Outreach Service. They in turn were busy trying to get in touch with the families involved to arrange an appointment. The team have had three DHBs visit or teleconference with them to learn and understand what they do to achieve such outstanding results. Two sent a member of staff to sit with each of the team members to learn how they do their job and find out how they can search for families with better success.

- The Medical Council of New Zealand has selected Canterbury DHB House Officer Katelyn Costello as its jurisdictional (New Zealand) nominee for the 2018 CPMEC Junior Doctor of the Year award. CPMEC is the Confederation of Postgraduate Medical Education Councils. Each year it recognises junior doctors and clinical educators/prevocational educational supervisors across Australia and New Zealand who have made valuable contributions to prevocational medical education and training. Katelyn has made a significant contribution to teaching and learning at Canterbury DHB and has multiple formal roles.
- The Kaupapa Maori and Pasifika non-governmental organisations based in Otautahi and known as the Maui Collective warmly welcomed their first NetP nurse in October. They celebrated with Tangata Atumotu Trust the inaugural placement of Registered Nurse Suli Tuitaupe. NetP is the Nursing Entry to Practice Programme which supports nursing graduates as they begin their careers in clinical practice. The role Suli accepted is a unique blended position working .5 FTE with Eastcare Health a general practice in Breezes Road and a .4 FTE position with Tangata Atumotu Trust, an NGO working in the community. Suli is passionate about improving Pasifika health and wants to make a difference to the wellbeing of one of the most deprived communities.
- Paul Barrett retired from his role as Pharmacy Services Manager, Christchurch, Ashburton Burwood, and Hillmorton hospitals in late October. He had worked at Canterbury DHB for 39 years and advised on the first and many subsequent computer systems used in Pharmacy.
- The only chapel in the world built to honour nurses killed during 20th century wars has re-opened following a complex year-long restoration project after it was devastated in the Canterbury earthquakes. The 90 year old Nurses' Memorial Chapel outside Christchurch Hospital was officially re-opened on Saturday by the Governor-General, the Right Honourable Dame Patsy Reddy. Friends of the Chapel President Pip Mason says the chapel is a special place for Christchurch nurses and they are delighted by the effort that has been put into restoring it.
- Over the last four decades, from the Clinical Engineering department's workshops, Gary Stevenson has worked tirelessly to ensure the smooth running and availability of medical equipment that is vital to saving lives and restoring health. His dedicated contribution to providing technical services for safe, effective, and innovative patient care was celebrated last month by Clinical Engineer Gary and his colleagues. Gary's drive, passion and hard work in Neonates has been instrumental in the procurement and functioning of critical clinical equipment throughout the department, assisting in saving the lives of newborn babies.

- **Te Panui Runaka:** For the past eight years, Canterbury woman Laura Bruce has been investigating public health concerns and providing advice and information to community leaders and the public in her role as a Health Protection Officer. She is eager to see more young people enter the profession and take advantage of a Community & Public Health scholarship, which supports Ngāi Tahu undergraduate students at the University of

Canterbury towards a career in health protection. The scholarship has been established to increase the number of Health Protection Officers of Ngāi Tahu descent.

FACILITIES REPAIR AND REDEVELOPMENT

General Earthquake repairs within Christchurch campus

- **Parkside Panels:** Cost estimate and programme for restraint of all panels on Parkside have been prepared. Final contractual items are being resolved for removal of panels above ASB Link. Work is expected to start on site prior to Christmas.
- **Clinical Service Block roof strengthening above Nuclear Medicine**: Equipment has now been received. The equipment will be stored at Print Place. Contractor selected and work is due to start 12 November.
- **Lab Stair 4:** EOI issued. Programme start date to be in 2nd quarter 2019 following completion of Diabetes building demolition. Relocation of Labs staff and other associated planning underway

Christchurch Women's Hospital

- **Stair 2:** Draft review completed by fire engineer as part of the overall Women's risk analysis. Strategic assessment process has been finalised and presented to facilities committee and for endorsement by board. The balance of fire analysis work is awaiting master plan before works can be programmed to complete strengthening works.
- **Level 4:** Crack injection around core to be undertaken. Parent room, kitchen and toilet areas complete. Difficulties gaining access to area due to patient levels, actively working with staff to look at options to commence the remedial and Passive fire works.
- **Level 5:** Small amount of work to corridor unable to commence due to operational constraints (NICU). Working with teams to identify a suitable time, but will endeavour to pick this up during Women's Passive fire works
- **Level 3:** All areas complete except reception, which is to be done at same time as stair strengthening to minimise disruption.

Other Christchurch Campus Works

- **Passive Fire/Main Campus Fire Engineering**
  - Database designs are complete, additional information added as test data received and in use by Site Redevelopment on current project / passive work. Currently developing the process for digitalization of the passive fire system and database. The forms and documents will be updated to e-forms and will be part of the digitalization programme. Continue discussion with Maintenance & Engineering on management of the passive fire programme.
  - Test rig being used weekly by CDHB and Engineers for training and evaluations. Materials supply is well established with savings being made.
  - Continue to identify non-compliant areas as other projects open walls / ceilings.
  - Second Stage RFP for installer fixed costs is in final stage of procurement progressing.
  - Passive program continues to receive positive support from wider industry representatives. Recently presented to Christchurch City Council building inspection team who fully support the process and accreditation.
  - Risk analysis and recommendation progressing slowly due to delay in releasing the master plan details. Works may need to be stopped until information is available.

- **Christchurch Hospital Campus Energy Centre**: This is managed by the Ministry of Health (*MoH*).
  - Service Tunnel: Complete. Steam provided by coal boilers to Outpatients and Hospital. Final connection for ASB still to be completed.
  - Energy Centre: ROI for boilers completed. Preferred Boiler supplier identified and to be advised shortly.
- **235 Antigua St and Boiler House (Demolition).** No work to be undertaken until new Energy Centre constructed and commissioned.
- **Temporary Accommodations on Antigua/Tuam St.** Construction started. Completion due early 2019.
- **Parkside Renovation Project to Accommodate Clinical Services, post ASB (managed by MoH):** Planning ongoing. This project is being managed by the MoH with close stakeholder involvement from the CDHB. Still waiting on advice from MoH as to outcome of master planning process. Draft master plans currently being peer reviewed by Ernst and Young.
- **Back up VIE Tank:** Initial proposed strengthening scheme has been approved by BOC. Quantity Surveyor has completed estimate. Business case to be presented shortly. Primary VIE tank is operational.
- **Antigua St Exit widening:** CDHB work completed in advance of Otakaro requirements.
- **New Outpatient Project (managed by MoH):** 1st and 2nd migration shift completed with only the hospital dental to come.
- **Avon Switch Gear and Transformer Relocation**. Design complete. Business case to be submitted for approval. Project is being managed by M&E.
- **Otakaro/CCC Coordination.** Oxford Gap closed to mid December 2018. Land swap agreed in principal however we await the outcome of a judicial review before any documentation can be formalised with LINZ. Regular Wednesday meetings are continuing with key stake holders. Crossing from main campus to Outpatients complete.
- **Hagley Outpatients 2 Storey demolition:** Business case approved. Contractor appointed. Working plan and programme complete. Work on site will begin 12 Nov 2018 following the Outpatients department relocation to the new building.
- **New Outpatients Cafeteria:** Business case approved. Main Contractor awarded. Fitout commenced. Completion forecast November 2018.
- **Diabetes Demolition**: Demolition to occur after Home Dialysis Training Centre has relocated to refurbished leased facility. Business case prepared ready for November meeting.
- **Canterbury Health Labs**
  - Anatomical pathology: Initial planning on options for repatriating AP form School of Medicine is about to commence. Business case for seed funding is pending
  - Core Lab (High Volume Automation) Upgrade: SRU to commence procurement of design consultants to develop scope for required building of infrastructure changes. Business case for seed funding is pending approval.
  - SRU is assisting CHL with strategy and planning on best use of the former Eye Outpatient facility.

Burwood Hospital Campus

- **Burwood New Build**: Defects are being addressed as they come to hand.

- **Burwood Admin old main entrance block:** Meeting held onsite to review the area. Meeting with community team leaders on 8 November to discuss requirements and numbers to be accommodated.
- **Burwood Mini Health Precinct:** User groups have been engaged with to identify space needs and expectations. Project delivery options, funding options and lease agreements are currently being discussed and need to be resolved before the project can proceed any further.
- **Spinal Unit:** Good progress being made. Foundation work to extension underway. 1st fix of services to existing areas has commenced.
- **Burwood Birthing/Brain Injury Demolition**: Work continues. Target completion date of 20th Dec 2018.
- **2nd MRI Installation:** MRI 2 works complete and fully operational.

Hillmorton Hospital Campus

- **Earthquake Works:** No earthquake works currently taking place. This will be reviewed once the outcome of the TPMH mental health business case has been advised.
- **Food Services Building:** Awaiting M&E assessment of chiller room, once this is received a business case to be submitted for approval.
- **Cotter Trust:** On-going occupation being resolved as part of overall site plan requirements. Meeting on site with Cotter Trust representatives
- **Mental Health Services:** New High Care Area for AT&R is in design development stage with all consultants working well. Resource consent to be lodged. Currently working on development for building 1 and 2 and temporary High Care Area for building 3. These include options for additional space in the PSAID area and opportunity's for a low stimulus area retrofitted into existing spaces.

The Princess Margaret Hospital Campus

- **Older Persons Health (*OPH*) Community Team Relocation:** The Feasibility study is now complete and work is to commence shortly on the options for repurposing the old Burwood Administration building to accommodate community teams.
- **Mental Health Services Relocation:** Indicative Business case approved by Ministers in Sep 2017. The Detailed Business Case is awaiting Ministry of Health and Capital Investment Committee approval.

Ashburton Hospital & Rural Campus

- **Stage 1 and 2 Works are Complete.** Final claims have been agreed with the contractor. Final defects resolution and retention release is protracted and expected to require several more months to resolve.
- **Tuarangi Plant Room**: Concept drawing completed and safety consultant report received. Now looking to hand over to M&E to implement.
- **New Boiler and Boiler House**: Consultants engaged and concept design complete. Will go out to the market shortly. Currently being managed by Maintenance & Engineering.

Other Sites/Work

- **Akaroa Health Hub:** In construction. Roof cladding is currently underway and it is targeted to complete first fix by the end of November. Programme remains at previous delay due to early winter weather. Anticipating completion approx. mid May 2019.

- **Kaikoura Integrated Family Health Centre:** Repair strategy received from Beca. Minor repairs to be undertaken by Maintenance & Engineering.
- **Rangiora Health Hub:** Main contractor appointed – HRS Construction. Work to begin at Christchurch on 12 November and has started at Rangiora.
- **Home Dialysis Relocation:** Business case approved by Board. Programme forecast completion March 2019. Contract awarded to Naylor Love and work has started on site.
- **SRU:** Project Management Office manuals re-write and systems overview. Scope has increased as understanding of documentation required has been realised to approximately 3 times original size. Main documentation is now 96% complete and is in use daily by the SRU team. Aligning with P3M3 process and documentation where appropriate.
- **Seismic Monitoring:** Fee proposals received from engineer. Business case being drafted.
- **Manawa (Formerly HREF):** SRU continues to be involved in providing construction and contract administration / interpretation advice to the Manawa project. Building has been blessed and is occupied. Currently in defect liability stage.

Project/Programme Key Issues

- The lack of a detailed Master Plan for the Hillmorton campus is still affecting our ability to provide a comprehensive EQ decision making assessment. We continue to use the framework adopting a more granular approach to determine outcomes.
- Additional peer reviews of Parkside and Riverside structural assessments, being undertaken by the MoH, are now complete. Clarity on the direction of the Master Planning process is required to plan the next stage of the POW.
- Delays to the POW continue to add risk outside the current agreed Board time frames. Key high risk areas of Panel replacement are starting, as instructed by the Facilities Committee and CDHB Board.
- Access to NICU to undertake EQ repairs to floors continues to be pushed out due to access constraints. SRDU is looking at options to decant teams to adjacent spaces to allow works to commence. This will, however, not be possible until the ASB project is complete and space in Parkside becomes available.
- Passive fire wall repairs continue to be identified. Repairs to these items are being completed before the areas are being closed up, but the budget for this has not been formalised. On-going repairs of these items, while essential, continue to put pressure on limited budgets and completion time frames.
- Potential passive fire issues around Comm floor 80 and use of all proof collars at outpatients, ASB and Burwood are currently under review and proposed solutions have been provided. We will work with contractors, designers and the MoH to ensure we get the appropriate systems installed.
- Impact of changes to the Building Act and Seismic assessment methodology continue to be assessed in relation to DHB buildings. Some buildings will be assessed at a higher % NBS than previously, but it is likely that more buildings will be deemed to be EQ prone than is currently the case. There are significant cost implications arising from these changes as strengthening schemes are likely to cost more and existing engineering reports are no longer valid as a basis for consentable strengthening work. The programme of works and business as usual projects are currently being reviewed in conjunction with the approved revised decision making framework in an attempt to identify tranches of work for commencement. This process is still largely dependent on master planning. Guidance from the Board will be

required as to the timing and suitability of any proposed projects to mitigate ongoing risks to the CDHB.

- Passive Fire: Risk analysis and recommendation progressing slowly due to delay in releasing the master plan details. Works may need to be stopped until information is available.

LIVING WITHIN OUR FINANCIAL MEANS

Live Within our Financial Means

- The consolidated Canterbury DHB financial result for the month of September 2018 was a deficit of $2.691M, which was $3.479M unfavourable against the draft annual plan surplus of $0.788M. The table below provides the breakdown of the September result.

	MONTH			YEAR TO DATE		
	Actual	Budget	Variance	Actual	Budget	Variance
	$M	$M	$M	$M	$M	$M
Governance	0.161	(0.00)	**0.162**	0.208	(0.00)	0.211
Funder	(4.360)	1.520	**(5.880)**	(14.853)	(7.393)	(7.460)
DHB Provider	1.507	(0.731)	**2.239**	(1.847)	(5.520)	3.673
Canterbury DHB Group Result	**(2.691)**	**0.788**	**(3.479)**	**(16.491)**	**(12.915)**	**(3.576)**

Report prepared by: David Meates, Chief Executive

DELIVERING AGAINST THE NATIONAL HEALTH TARGETS		Q1	Q2	Q3	Q4	Target	Status
 **Shorter Stays in ED** Patients admitted, discharged or transferred from an ED within 6 hours	Canterbury DHB just missed the Shorter stays in ED health target in quarter four with 94% of patients admitted, discharged or transferred from ED within 6 hours. The Acute Demand Management Service continues to play a critical role in keeping people well in the community and avoiding unnecessary presentations to ED. More than 8,135 acute demand packages of care were provided in quarter four, more than 32,000 were provided during the year.	94%	95%	95%	94%	95%	✘
 **Improved Access to Elective Surgery** Canterbury's volume of elective surgery	Canterbury DHB met the year end improved access to elective surgery health target with 21,402 elective surgeries, against the target of 21,330.	4,989 (90%)	10,344 (96%)	15,341 (97%)	21,402	21,330	✓
 **Increased Immunisation** Eight-month-olds fully immunised	Canterbury DHB achieved the increased immunisation health target with 95% of eligible children fully vaccinated at eight months. Canterbury met the target for all ethnicities this quarter (96% Asian, 99% Pacific 100%, Maori 95%, and New Zealand European 96%).	95%	95%	95%	95%	95%	✓
 **Better Help for Smokers to Quit** Smokers enrolled in primary care receiving help and advice to quit	Canterbury DHB achieved the better help for smokers to quit target in quarter three with 93% of smokers enrolled with a PHO offered advice and help to quit smoking against the 90% target. Canterbury DHB's cessation support indicator is again the highest in the country at 60%. This indicator shows the percentage of current smokers who have taken the next step from brief advice and accepted an offer of cessation support services in the last 15 months.	91%	90%	91%	93%	90%	✓
 **Faster Cancer Treatment** Patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer	In the last 3 months (June, July and August) Canterbury DHB achieved the Faster Cancer Treatment (FCT) target with 93% of patients receiving their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer.	95%	94%	91%	94%	90%	✓
 **Raising Healthy Kids** Percent of children identified as obesity at their B4SC offered a referral for clinical assessment and healthy lifestyle intervention	Canterbury DHB achieved the raising healthy kids target in quarter four with 100% of four-year-olds identified as above the 98th centile for their BMI (height and weight measurement) referred for clinical assessment and healthy lifestyle intervention. This is a 2% increase on the previous quarter. 'Referrals declined' fell slightly to 22% this quarter.	93%	96%	98%	100%	95%	✓

SEEING OUR SYSTEM

Canterbury District Health Board
Te Poari Hauora ō Waitaha

NOTES ONLY PAGE

FINANCE REPORT 30 SEPTEMBER 2018

Canterbury District Health Board
Te Poari Hauora ō Waitaha

TO: **Chair and Members**
Canterbury District Health Board

SOURCE: **Finance**

DATE: **15 November 2018**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

This is a regular report and standing agenda item providing an update on the latest financial results and other relevant financial matters to the Board of the Canterbury DHB. A more detailed report is presented to and reviewed by the Quality, Finance, Audit and Risk Committee monthly, prior to this report being prepared.

2. RECOMMENDATION

That the Board:

i. notes the financial result for the period ended 30 September 2018.

3. DISCUSSION

Overview of September 2018 Financial Result

The consolidated Canterbury DHB financial result for the month of September 2018 was a deficit of $2.691M, which was $3.479M unfavourable against the draft annual plan surplus of $0.788M. The table below provides the breakdown of the September result.

	MONTH			YEAR TO DATE		
	Actual	Budget	Variance	Actual	Budget	Variance
	$M	$M	$M	$M	$M	$M
Hospital & Specialist Service and Corporate	1.395	(0.771)	**2.166**	(2.055)	(5.531)	3.476
Community & Public Health	0.041	(0.034)	**0.075**	0.006	(0.137)	0.143
Total In-House Provider excl Subsidiaries	**1.436**	**(0.805)**	**(2.241)**	**(2.049)**	**(5.668)**	**3.619**
Add: Funder & Governance						
Funder Revenue	140.138	142.799	(2.661)	413.706	417.404	(3.698)
External Provider Expense	(63.447)	(60.253)	(3.194)	(185.407)	(181.719)	(3.688)
Internal Provider Expense	(81.051)	(81.026)	(0.025)	(243.152)	(243.078)	(0.074)
Total Funder	**(4.360)**	**1.520**	**(5.880)**	**(14.853)**	**(7.393)**	**(7.460)**
Governance & Funder Admin	0.161	(0.001)	0.162	0.208	(0.002)	0.211
Total Canterbury DHB (Parent)	**(2.763)**	**0.715**	**(7.959)**	**(16.693)**	**(13.063)**	**(3.630)**
Add: Subsidiaries						
Brackenridge Estate Ltd	0.020	0.042	**(0.021)**	0.100	0.128	(0.028)
Canterbury Linen Services Ltd	0.051	0.032	**0.019**	0.103	0.020	0.083
Canterbury DHB Group Surplus / (Deficit)	**(2.691)**	**0.788**	**(3.479)**	**(16.491)**	**(12.915)**	**(3.576)**

4. APPENDICES

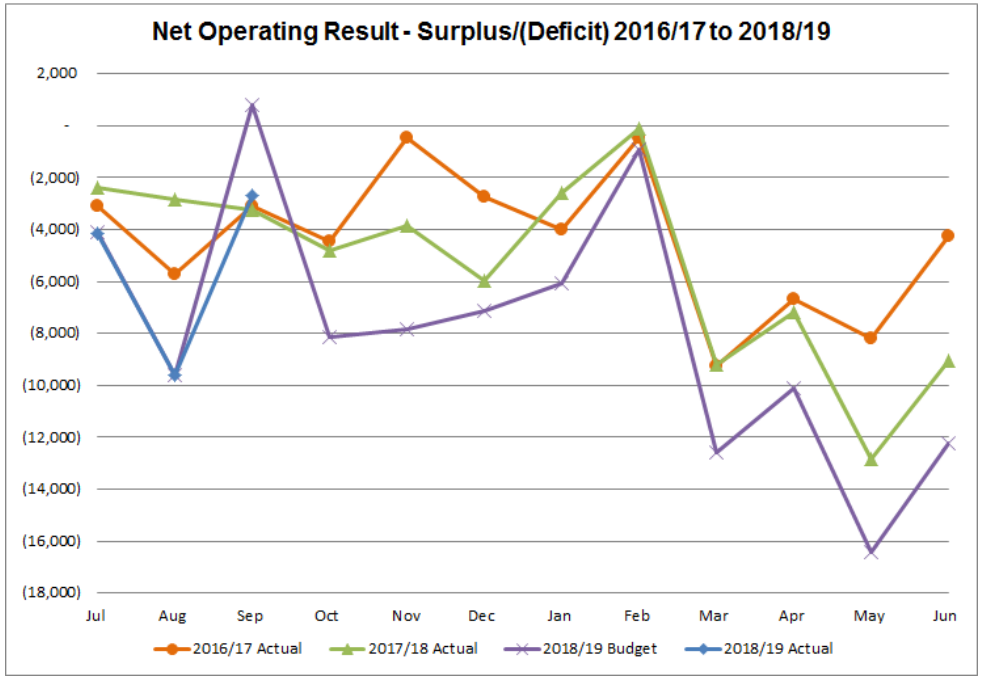
Appendix 1: Financial Result
Appendix 2: Statement of Comprehensive Revenue & Expense
Appendix 3: Statement of Financial Position
Appendix 4: Cashflow

Report prepared by: Justine White, Executive Director, Finance & Corporate Services

APPENDIX 1: FINANCIAL RESULT

FINANCIAL PERFORMANCE OVERVIEW – PERIOD ENDED 30 SEPTEMBER 2018

	Month Actual $'000	Month Budget $'000	Month Variance $'000		YTD Actual $'000	YTD Budget $'000	YTD Variance $'000	
Surplus/(Deficit)	(2,691)	788	(3,479)	-442% ✗	(16,491)	(12,915)	(3,576)	28% ✗



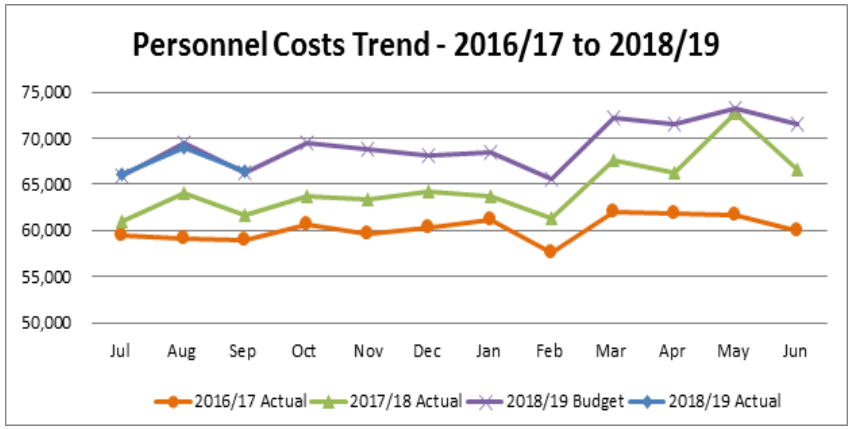
Our draft 18/19 Annual Plan is a deficit of $94.517M.

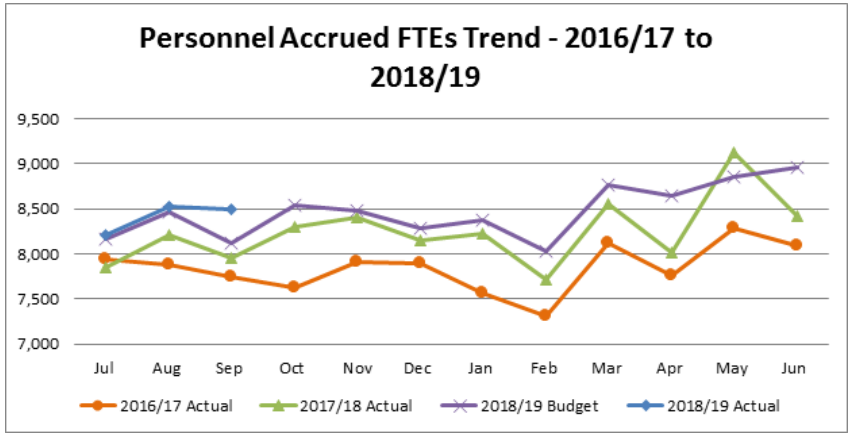
Note there are risks around wash-ups on some revenue streams such as electives funding, and IDF wash-ups that may differ from what we accrued at year end and will come through in this financial year.

KEY RISKS AND ISSUES

We expect to continue to incur earthquake related repair and maintenance expenditure and the depreciation impacts of quake related capital spend for a significant number of years into the future. There will be variability between the expected and actual timing of these costs. New facilities coming on stream will attract additional capital charge and depreciation expense.

PERSONNEL COSTS/PERSONNEL ACCRUED FTE





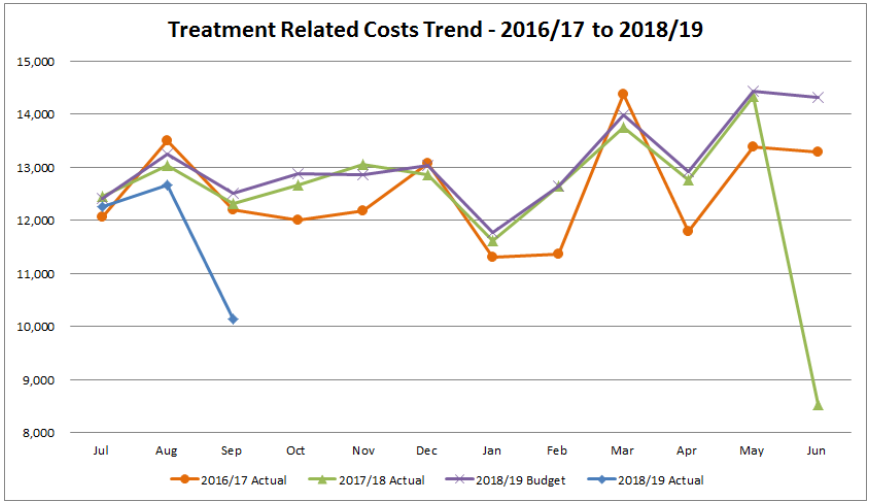
KEY RISKS AND ISSUES

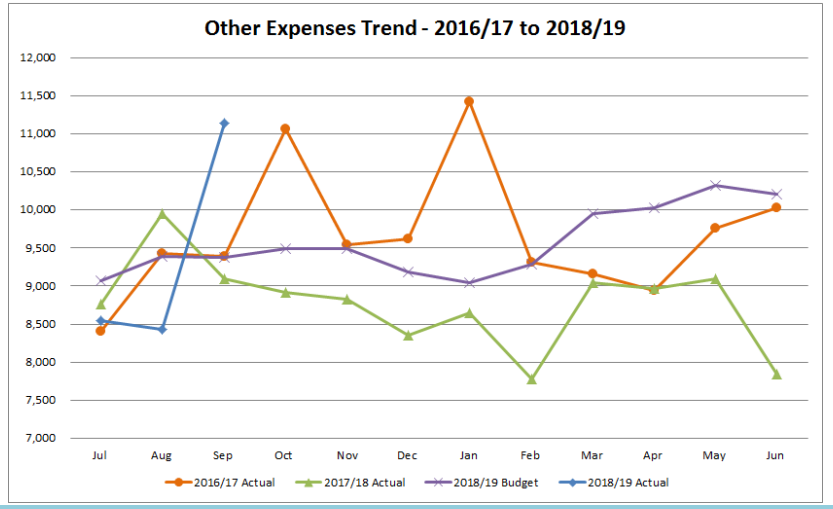
Pressure will continue on personnel costs into the foreseeable future, as a result of settlements as well as additional resource required for the new ASB redevelopment.

We are yet to assess the full implication of potential minimum wage increments, including the timing that is proposed for these, and the relativity impacts that this will create on other workforce groups that are not otherwise directly impacted.

We have not made any provision for Holidays Act compliance issues that the Sector is currently working through. The impact for CDHB is at this stage unquantifiable, given the complexity of the current interpretation in regard to the sector.

TREATMENT & OTHER EXPENSES RELATED COSTS





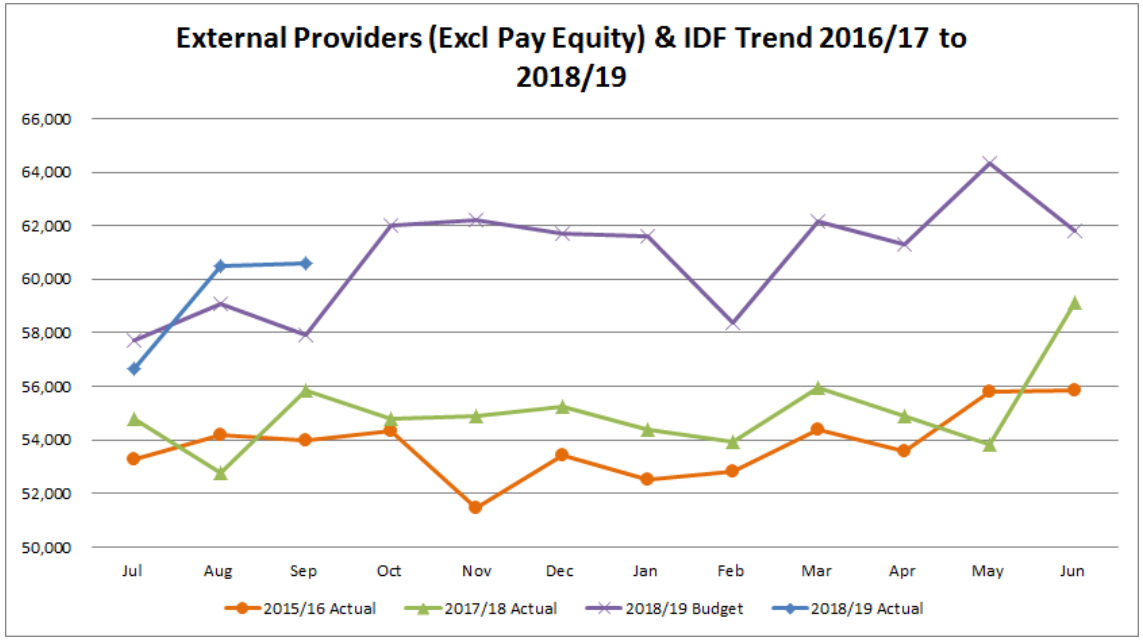
KEY RISKS AND ISSUES

Treatment related costs are influenced by activity volume, as well as complexity of patients.

Additional facility costs continue to be incurred in relation to The Princess Margaret Hospital campus. Some of these additional costs are in relation to a number of mental health services that remain stranded at that site. Earthquake expenditure is lower than planned due to the timing of the repairs, and the split between capex and opex repairs.

EXTERNAL PROVIDER COSTS

	Month Actual $'000	Month Budget $'000	Month Variance $'000			YTD Actual $'000	YTD Budget $'000	YTD Variance $'000		
Total External Provider Costs	63,447	60,253	(3,194)	-5%	✗	185,407	181,719	(3,688)	-2%	✗
Pay Equity	2,828	2,313	(515)	-22%	✗	7,622	6,938	(684)	-10%	✗
External Provider costs excl Pay Equity	60,619	57,941	(2,679)	-5%	✗	177,785	174,782	(3,004)	-2%	✗



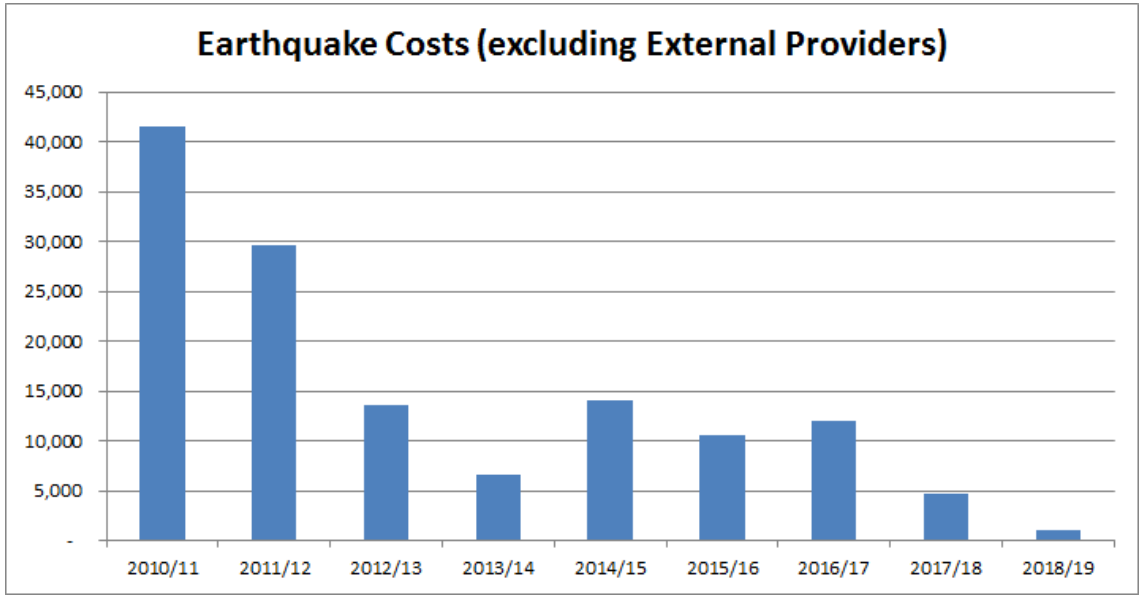
YTD pharmaceutical spend in relation to PCT costs is reflected in External Provider costs this year, but the budget is currently in the Provider Arm Treatment Related Costs budget. This will be adjusted when we send a revised budget to the MoH.

KEY RISKS AND ISSUES

Additional outsourcing to meet electives targets may be required. Additionally, there is uncertainty on the impact on community rebates as a result of recent PHARMAC changes.

EARTHQUAKE

Data in this table excludes the Kaikoura earthquakes	Month Actual	Month Budget	Month Variance			YTD Actual	YTD Budget	YTD Variance		
	$'000	$'000	$'000			$'000	$'000	$'000		
Total Earthquake Revenue (Draw Down)	**291**	**300**	**(9)**	**100%**	✗	**533**	**900**	**(367)**	**100%**	✗
Earthquake Costs - Repairs	361	300	(61)	100%	✗	601	900	299	100%	✓
Earthquake Costs - External Provider	1,431	1,431	-	100%	✓	4,293	4,293	-	100%	✓
Earthquake Costs - Non Repairs	143	143	-	100%	✓	396	396	-	100%	✓
Total Earthquake Costs	**1,935**	**1,874**	**(61)**	**100%**	✗	**5,290**	**5,589**	**299**	**100%**	✓



Earthquake (EQ) operating costs include EQ repair works and other non-repair related costs such as additional security and building leases.

EQ repair (integral part of the DHB EQ Programme of Works) costs are offset by an equivalent amount of insurance revenue that will be progressively drawn down to minimise the impact of EQ repair costs on the net result. The insurance revenue relates to the portion of earthquake insurance settlement amount that was repaid to the Crown in 2013/14 for future draw down by the DHB as and when appropriate to fund the earthquake repairs and programme of works.

Note: 'Quake' costs associated with additional funder activity such as increased outsourced surgery are captured under external provider costs.

KEY RISKS AND ISSUES

The variability and uncertainty of these costs will continue to put pressure on meeting our monthly budgets in future periods.

FINANCIAL POSITION

	YTD Actual $'000	YTD Budget $'000	Variance $'000		
Equity	479,781	504,357	(24,576)	-5%	✗
Cash	(35,775)	(8,187)	(27,588)	337%	✗

KEY RISKS AND ISSUES

If future deficit funding is less than the expected amount, cash flows will be impacted, and the ability to service payments as and when they fall due will become a potential issue.

APPENDIX 2: CANTERBURY DHB GROUP STATEMENT OF COMPREHENSIVE REVENUE AND EXPENSE

The Group financial results include Canterbury DHB and its subsidiaries, Canterbury Linen Services Ltd and Brackenridge Services Ltd
For the month of September 2018

Month					Year to Date				Annual
18/19 Actual	18/19 Budget	17/18 Actual	Variance to Budget		18/19 Actual	18/19 Budget	17/18 Actual	Variance to Budget	18/19 Budget
146,997	148,581	137,279	(1,584) ✗	MoH Revenue	432,131	434,750	412,597	(2,619) ✗	1,740,353
3,625	3,148	3,679	477 ✓	Patient Related Revenue	11,614	9,444	12,410	2,170 ✓	37,172
3,439	4,290	2,469	(851) ✗	Other Revenue	9,162	12,640	8,777	(3,478) ✗	52,397
154,062	**156,019**	**143,427**	**(1,957)**	**Total Operating Revenue**	**452,907**	**456,834**	**433,784**	**(3,927)**	**1,829,922**
66,407	66,284	61,711	(123) ✗	Personnel Costs	201,592	201,737	186,787	145 ✓	830,778
10,134	12,502	12,324	2,368 ✓	Treatment Related Costs	35,041	38,153	37,815	3,112 ✓	156,956
63,447	60,253	56,495	(3,194) ✗	External Service Providers	185,407	181,719	168,356	(3,688) ✗	737,301
11,139	9,375	9,097	(1,764) ✗	Other Expenses	28,125	27,836	27,787	(289) ✗	114,840
151,127	**148,414**	**139,627**	**(2,713)** ✗	**Total Operating Expenditure**	**450,165**	**449,445**	**420,746**	**(720)** ✗	**1,839,875**
2,935	**7,605**	**3,801**	**(4,670)** ✗	**Total Surplus / (Deficit) Before Indirect Items**	**2,741**	**7,389**	**13,038**	**(4,648)** ✗	**(9,953)**
106	148	59	(42) ✗	Interest	292	444	207	(152) ✗	1,778
1,401	290	234	1,111 ✓	Donations	2,044	915	240	1,129 ✓	4,027
1	-	(8)	1 ✓	Profit / (Loss) on Sale of Assets	5	-	(8)	5 ✓	-
1,508	**438**	**284**	**1,070** ✓	**Total Indirect Revenue**	**2,341**	**1,359**	**439**	**982** ✓	**5,805**
2,455	2,455	2,568	- ✓	Capital Charge	7,364	7,365	7,704	1 ✓	29,494
4,636	4,762	4,769	126 ✓	Depreciation	14,166	14,184	14,230	18 ✓	60,430
43	38	-	(5) ✗	Interest Expense	43	114	-	71 ✓	450
7,134	**7,255**	**7,337**	**121** ✓	**Total Indirect Expenses**	**21,573**	**21,663**	**21,934**	**90** ✓	**90,374**
(2,691)	**788**	**(3,252)**	**(3,479)** ✗	**Total Surplus / (Deficit)**	**(16,491)**	**(12,915)**	**(8,457)**	**(3,576)** ✗	**(94,522)**

APPENDIX 3: CANTERBURY DHB GROUP STATEMENT OF FINANCIAL POSITION

As at 30 September 2018

Unaudited 30-Jun-18 $'000		Group Actual 30-Sep-18 $'000	YTD Group Budget 30-Sep-18 $'000	Annual Group Budget 30-Jun-19 $'000
517,833	Opening Equity	496,272	496,272	496,272
42,398	Net Equity Injections / (Repayments) During Year	-	21,000	149,098
(63,959)	Operating Results for the Period	(16,491)	(12,915)	(94,522)
496,272	**TOTAL PUBLIC EQUITY**	479,781	504,357	550,848
	Represented By:			
	Current Assets			
1,677	Cash & Cash Equivalents	2,914	-	-
750	Short Term Investments	750	750	750
87,165	Trade and Other Receivables	95,360	87,165	87,164
4,554	Prepayments	9,895	4,554	4,554
11,171	Inventories	10,569	11,171	11,171
10,561	Restricted Assets	12,724	10,560	10,561
115,878	**Total Current Assets**	132,212	114,200	114,200
	Less Current Liabilities			
17,376	Overdraft	38,689	8,187	42,446
111,189	Trade and Other Payables	122,631	118,556	111,191
10,577	Restricted Funds	12,768	10,575	10,575
172,699	Employee Benefits	166,078	164,687	164,687
311,841	**Total Current Liabilities**	340,166	302,005	328,899
(195,963)	**Working Capital**	(207,954)	(187,805)	(214,699)
	Non Current Assets			
16	Restricted Funds	16	16	16
5,186	Investment in NZHPL	5,186	5,186	5,186
693,197	Fixed Assets	688,790	693,137	766,522
698,399	**Term Assets**	693,992	698,339	771,724
	Non Current Liablilties			
6,164	Employee Benefits	6,257	6,177	6,177
6,164	**Term Liabilities**	6,257	6,177	6,177
496,272	**NET ASSETS**	479,781	504,357	550,848

APPENDIX 4: CASHFLOW

Unaudited 30-Jun-18 $'000		Actual 30-Sep-18 $'000	YTD Budget 30-Sep-18 $'000	Budget 30-Jun-19 $'000
	CASHFLOW FROM OPERATING ACTIVITIES			
(5,124)	**Net Cash from Operating Activities**	(11,519)	635	(42,091)
	CASHFLOW FROM INVESTING ACTIVITIES			
(38,453)	**Net Cash from Investing Activities**	(8,558)	(14,123)	(61,754)
	CASHFLOW FROM FINANCING ACTIVITIES			
42,398	**Net Cash from Financing Activities**	-	21,000	77,098
(1,179)	Overall Increase/(Decrease) in Cash Held	(20,077)	7,512	(26,747)
(14,520)	Add Opening Cash Balance	(15,699)	(15,699)	(15,699)
(15,699)	**Closing Cash Balance**	(35,776)	(8,187)	(42,446)

MĀORI AND PACIFIC HEALTH PROGRESS REPORT

Canterbury District Health Board
Te Poari Hauora ō Waitaha

TO: **Chair and Members**
Canterbury District Health Board

SOURCE: **Executive Director, Māori and Pacific Health**

DATE: **15 November 2018**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

This report provides an update on progress and activities pertaining to Māori and Pacific Health.

2. RECOMMENDATION

That the Board, as recommended by the Community & Public Health and Disability Support Advisory Committee:

i. notes the Māori and Pacific Health Progress Report.

3. DISCUSSION

Canterbury Māori Health Dashboard Report

Attached (Appendix 1), is the latest Canterbury Māori Health Dashboard Report against targets set from the 2017/18 Māori Health Action Plan. The Māori Health Dashboard Report is primarily a monitoring document and we measure our performance across a range of targets, although it represents a small part of the actual targeted activity for our Māori population in Canterbury.

The Canterbury DHB focuses on priority areas that show how the system is working towards Pae Ora. We seek to reduce and eliminate the health inequities that have long persisted in the Māori population as a step towards pae ora for Māori in our community.

Although we have much more work to do, the dashboard shows some improvement trending in children's oral health, which is encouraging. There are also encouraging signs in the improvement of eligible Māori women cervical screening.

Canterbury Pacific Health Dashboard Report

Attached (Appendix 2), is the latest Canterbury Pacific Health Dashboard Report. The Pacific Health Dashboard Report, like its Māori sibling, is primarily a monitoring document and we measure our performance across a range of targets, although it represents a small part of the actual targeted activity for our Pacific population in Canterbury.

The Canterbury DHB focuses on priority areas that show how the system is working towards reducing and eliminating the health inequities that have also long persisted in the Pacific population.

Again, although we have much more work to do, the dashboard shows some improvement trending in children's oral health enrolment, which is encouraging. There are also encouraging signs in the improvement of HPV immunisation.

Please note the tables below both the Māori and Pacific dashboards which describe the measure, data source and period of latest results for each indicator. There is a lag time between some of the data being received and the Ministry of Health (*MoH*) publishing the data. These dashboards represent the latest data.

National Māori Health Indicators Dashboard Report

Attached (Appendix 3), is the latest National Māori Health Indicators Report (sourced from http://trendly.co.nz), which enables us to compare performance by ethnicity (Māori vs non-Māori), and by DHB.

The target field is blank where there is no target, or the indicator assigned by the MoH is a specific target tailored for each DHB. Rheumatic fever is not displayed in the dashboard table because the MoH reports total population and South Island data is aggregated.

The report demonstrates that although Canterbury is one of the better performing DHBs for our Māori population, there are still stark differences between Māori and non-Māori across all DHBs, but we are making progress towards improving. Such comparisons provide compelling data as to why we should be targeting Māori to reduce inequity in our system.

4. APPENDICES

Appendix 1: Canterbury Māori Health Dashboard Report, October 2018.
Appendix 2: Canterbury Pacific Health Dashboard Report, October 2018.
Appendix 3: National Māori Health Indicators Dashboard Report, October 2018.

Report prepared by: Hector Matthews, Executive Director, Māori and Pacific Health

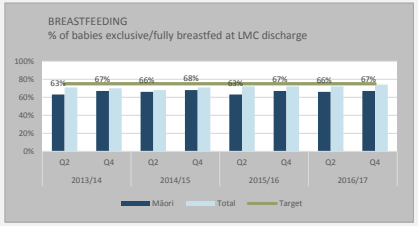
Canterbury DHB Māori Health Action Dashboard Report

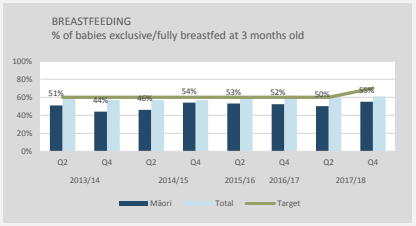
October 2018

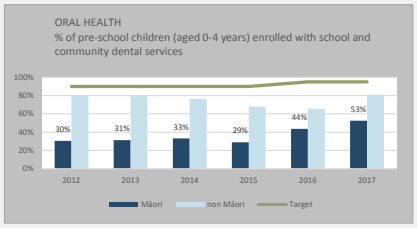
Kia whakakotahi te hoe o te waka
WE PADDLE OUR WAKA AS ONE

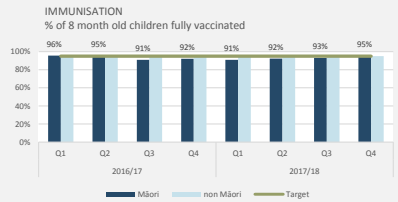
The difference between Māori and non Māori is less than 5% or the target is met
The difference between Māori and non Māori is between 5% and 10%
The difference between Māori and non Māori is grater than 10%

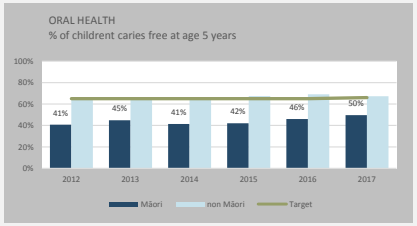
Tamariki Health and Wellbeing

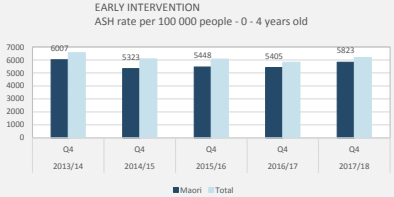


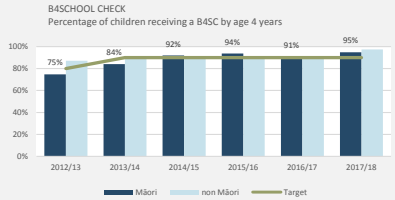


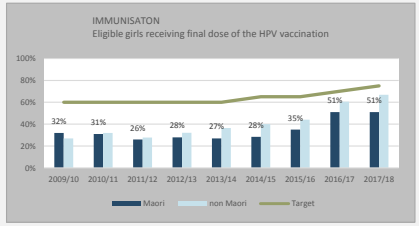


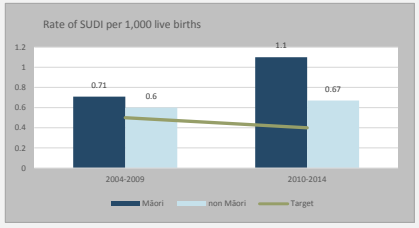




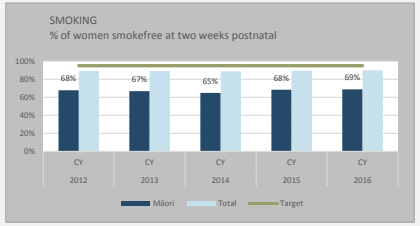


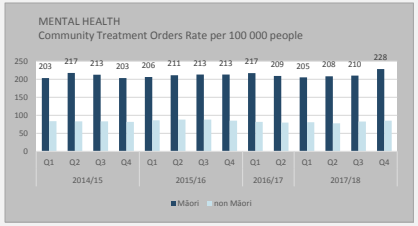


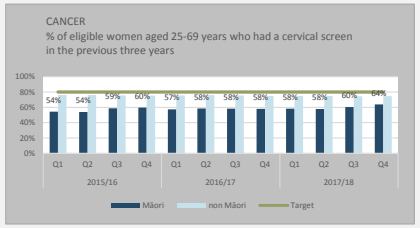


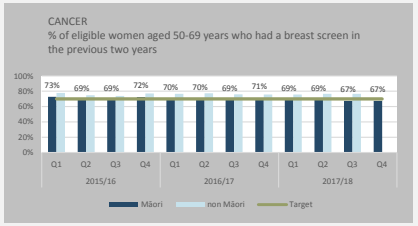


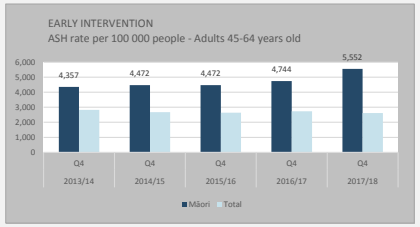
Adult Health and Wellbeing

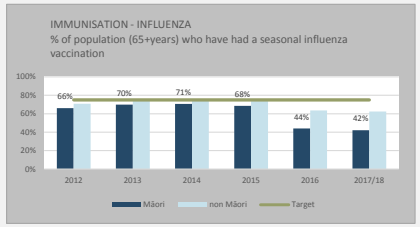




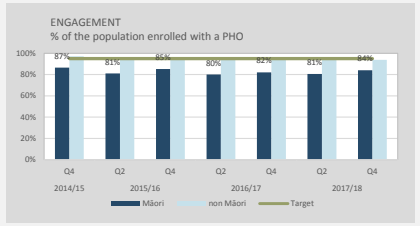


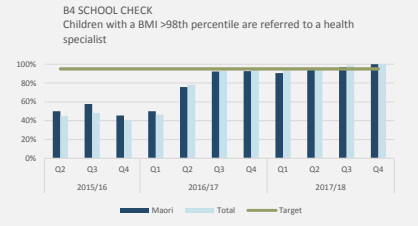






Enablers to support Improved Health and Wellbeing

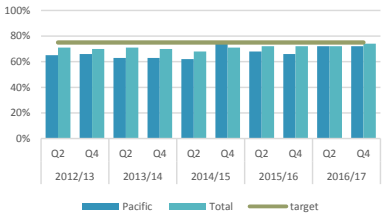




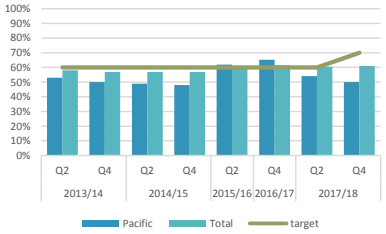
Indicator Full Name	Data Source	Latest Reporting Period	Data Release Date	Notes
Infants are exclusively or fully breastfed at discharge from LMC	National Maternity Collection (MAT)	Apr - Jun 2017	Mar 2018	Data may be incomplete, excluding data where records have no status
Infants are exclusively or fully breastfed at three months	Well Child Tamariki Ora (WCTO) National Dataset	Jul - Dec 2017	May 2018	
Percentage of Infants fully vaccinated at eight months	National Immunisation Register	Apr - Jun 2018	Jul 2018	
Children aged 0-4 years are enrolled with the Community Oral Health Service	Canterbury DHB Community Oral Health Service database "Titanium"	Jan - Dec 2017	Mar 2018	Results are provided annually in line with the school year. The next release is expected in March 2019
ASH rates per 100,000 Children 0-4 years old	National Minimum Dataset (NMDS)	Jun 2014 -Jun 2018	October 2018	
B4SCs are started before children are 4½ years	B4 School Check	Jul 2017 - Jun 2018	Jul 2018	
Percentage of children caries-free for 5 years	Canterbury DHB Community Oral Health Service database "Titanium"	Jan - Dec 2017	Apr 2018	Results are provided annually in line with the school year. The next release is expected in March 2019
Percentage of eligible girls receiving final dose of the HPV immunisation	National Immunisation Register	Apr - Jun 2018	Jul 2018	
Rate of SUDI per 100,00 live births	The Mortality Collection (MORT)	Jan 2010 - Dec 2014	Jan 2017	Due to small numbers, SUDI data is release every five years. Release of next series is expected in 2019
Percentage of Women Smokefree at two weeks postnatal	National Maternity Collection (MAT)	Jan - Dec 2016	Apr 2018	MAT data can take up to two years to show all events which may explain deviation between reports
Population under Mental Health Act: section 29 Community Treatment Orders, rate per 100 000 population	Project for the Integration of Mental Health Data (PRIMHD)	Apr-18	Apr 2018	Data is provided 3 months in arrears for each reporting quarter
Women aged 25-69, who have had a cervical smear once in the last three years	National Screening Unit	Apr - Jun 2018	Jul 2018	
Women aged 50-69, who have had a breast screen once in the last two years	National Screening Unit	Apr - Jun 2018	Jul 2018	
ASH rates per 100,000 Adults 45-64 years old	National Minimum Dataset (NMDS)	Jun 2014 -Jun 2018	October 2018	
Percentage of population (65+years) who have had a seasonal influenza vaccination	National Immunisation Register	Mar - Sep 2017	Sep 2017	This meausre has changed from using PHO enrolled populaiton data to census population data. The reporting dates have changed from 2016, the reporting period now covers Mar- Sep where previously this was Jan-Dec. Results are not directly comparible between 2017 and previous years.
Percentage of the population enrolled with a PHO	Canterbury DHB data Q2 onwards PHO Enrolment Collection	Apr - Jun 2018	Jul 2018	
Children with a BMI >98th percentile are referred to a health specialist	B4 School Check	Apr - Jun 2018	Jul 2018	

Pacific Health Dashboard
October 2018

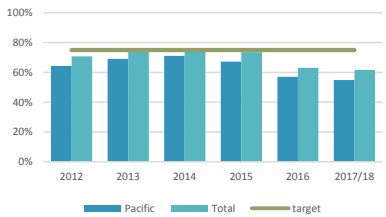
BREASTFEEDING
Babies exclusively and fully breastfed at LMC discharge



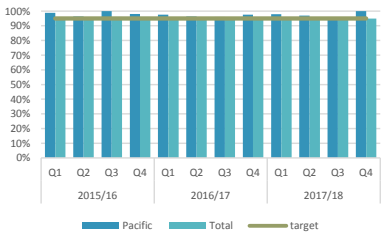
BREASTFEEDING
Babies exclusively and fully breastfed at 3 months



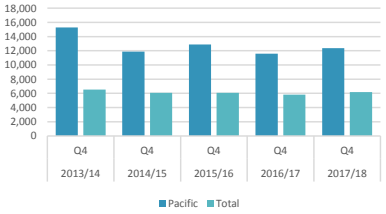
IMMUNISATION
Eligible population (aged 65y+) who have had a seasonal influenza vaccination



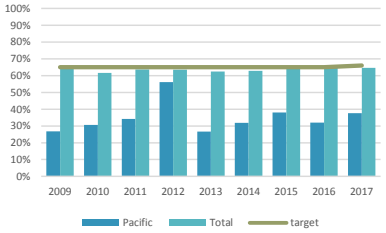
IMMUNISATION
Infants fully immunised by eight months of age



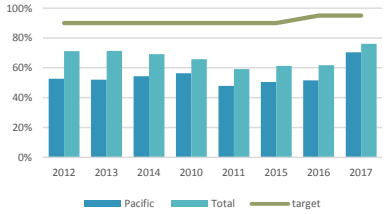
EARLY INTERVENTION
ASH rate for children 0-4 years old, per 100,000 population



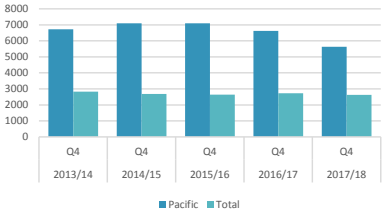
ORAL HEALTH
Children carries-free (no holes or fillings) at age 5



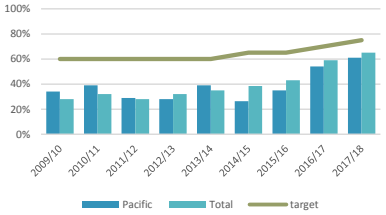
ORAL HEALTH
Children aged under 5 enrolled in DHB community oral health service



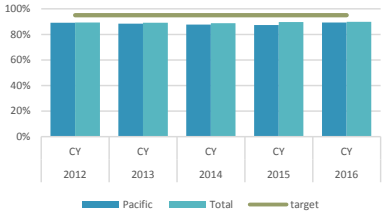
EARLY INTERVENTION
ASH rate for adults 45-64 years old, per 100,000 population



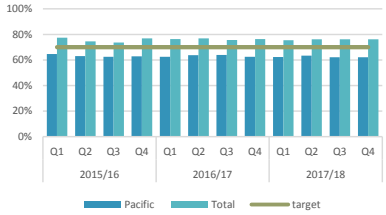
IMMUNISATION
Eligible girls receiving final dose of the HPV vaccination



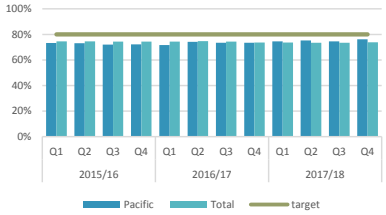
SMOKING
Women who are smokefree at two weeks postnatal



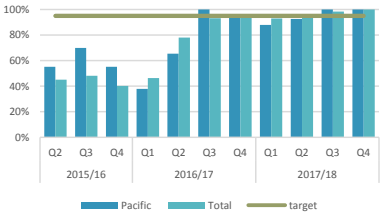
CANCER
Women aged 50-69, who have had a breastscreen once in the last two years



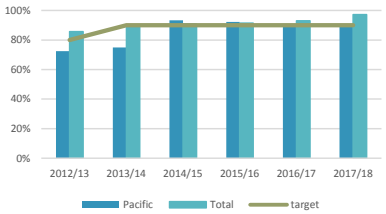
CANCER
Women aged 25-69, who have had a cervical smear once in the last three years



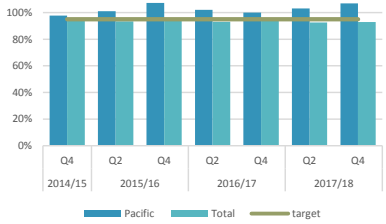
EARLY INTERVENTION
Children with a BMI >98th percentile are referred to a health specialist



B4SC
Percentage of children receiving a B4SC by age 4 years



ENGAGEMENT
Population enrolled with a PHO



Indicator Full Name	Data Source	Latest Reporting Period	Data Release Date	Notes
Infants are exclusively or fully breastfed at discharge from LMC	National Maternity Collection (MAT)	Apr - Jun 2017	Mar 2018	Data may be incomplete, excluding data where records have no status
Infants are exclusively or fully breastfed at three months	Well Child Tamariki Ora (WCTO) National Dataset	Jul - Dec 2017	May 2018	
ASH rates per 100,000 Children 0-4 years old	National Minimum Dataset (NMDS)	Jun 2014 -Jun 2018	October 2018	
Children with a BMI >98th percentile are referred to a health specialist	B4 School Check	Apr - Jun 2018	Jul 2018	
Percentage of eligible girls receiving final dose of the HPV immunisation	National Immunisation Register	Apr - Jun 2018	Jul 2018	
Percentage of Women Smokefree at two weeks postnatal	National Maternity Collection (MAT)	Jan - Dec 2016	Apr 2018	MAT data can take up to two years to show all events which may explain deviation between reports
ASH rates per 100,000 Children 45-64 years old	National Minimum Dataset (NMDS)	Jun 2014 -Jun 2018	October 2018	
Percentage of population (65+years) who have had a seasonal influenza vaccination	National Immunisation Register	Mar - Sep 2017	Sep 2017	This measure has changed from using PHO enrolled population data to census population data. As such the results are not directly comparable between 2016 and previous years.
Percentage of Infants fully vaccinated at eight months	National Immunisation Register	Apr - Jun 2018	Jul 2018	
Children aged 0-4 years are enrolled with the Community Oral Health Service	Canterbury DHB Community Oral Health Service database "Titanium"	Jan - Dec 2017	Mar 2018	Results are provided annually in line with the school year. The next release is expected in March 2019
Percentage of children caries-free for 5 years	Canterbury DHB Community Oral Health Service database "Titanium"	Jan - Dec 2017	Apr 2018	Results are provided annually in line with the school year. The next release is expected in March 2019
B4SCs are started before children are 4½ years	B4 School Check	Jul 2017 - Jun 2018	Jul 2018	
Women aged 50-69, who have had a breast screen once in the last two years	National Screening Unit	Apr - Jun 2018	Jul 2018	
Women aged 25-69, who have had a cervical smear once in the last three years	National Screening Unit	Apr - Jun 2018	Jul 2018	
Percentage of the population enrolled with a PHO	Canterbury DHB data	Apr - Jun 2018	Jul 2018	

National Māori Health Indicators - October 2018

Non-Māori

Indicator	Data Period	Target	Auckland	Bay of Plenty	Canterbury	Capital & Coast	Counties Manukau	Hawke's Bay	Hutt Valley	Lakes	Mid Central	Nelson Marlborough	Northland	South Canterbury	Southern	Tairawhiti	Taranaki	Waikato	Wairarapa	Waitemata	West Coast	Whanganui	Reached Target
PHO Enrolment	Jul-Sep 2018	90%	81.0%	100.0%	93.0%	93.0%	92.0%	98.0%	100.0%	95.0%	94.0%	98.0%	99.0%	99.0%	93.0%	96.0%	96.0%	95.0%	101.0%	92.0%	95.0%	99.0%	19
ASH (0-4 yrs)	Yr to Sep 17	-	5308	6650	5905	5012	4447	4741	8143	8254	5868	3638	5747	3448	5615	5607	6303	7181	5824	4391	4625	7315	-
ASH (45-64 yrs)	Yr to Sep 17	-	2704	3059	2504	2530	2867	3313	3920	4222	4147	2356	3396	3758	2868	3007	4492	3426	3478	3489	2614	4988	-
Breastfeeding (6 wks)	Jan-Jun 2017	75%	75.0%	79.0%	73.0%	75.0%	69.0%	78.0%	70.0%	77.0%	71.0%	73.0%	82.0%	75.0%	76.0%	85.0%	73.0%	73.0%	71.0%	77.0%	74.0%	73.0%	10
Breastfeeding (3 mths)	Jan-Jun 2017	70%	65.0%	66.0%	63.0%	67.0%	51.0%	62.0%	56.0%	59.0%	60.0%	63.0%	69.0%	61.0%	64.0%	65.0%	59.0%	60.0%	54.0%	65.0%	62.0%	60.0%	0
Breastfeeding (6 mths)	Jan-Jun 2016	65%	78.8%	72.4%	67.2%	78.9%	66.3%	68.4%	69.5%	62.5%	58.3%	72.3%	77.1%	63.3%	64.9%	69.5%	68.0%	67.3%	72.1%	73.9%	62.0%	52.2%	14
Breast Screening (50-69 yrs)	Apr-Jun 2018	70%	63.7%	73.6%	75.4%	72.6%	71.8%	74.0%	73.5%	71.5%	77.0%	79.0%	70.3%	76.6%	74.7%	72.1%	76.5%	70.6%	76.9%	65.3%	75.2%	79.9%	18
Cervical Screening (25-69 yrs)	Apr-Jun 2018	80%	65.5%	83.4%	75.0%	78.2%	70.3%	76.5%	76.3%	78.3%	77.5%	81.5%	77.0%	78.2%	78.3%	78.9%	82.8%	77.7%	78.3%	71.8%	75.7%	77.6%	3
Immunisation (8 mths)	Apr-Jun 2018	95%	94.1%	85.3%	95.7%	94.7%	94.0%	92.4%	94.5%	90.4%	92.4%	93.7%	84.4%	93.8%	93.8%	94.7%	90.5%	91.5%	94.7%	92.1%	93.0%	86.7%	1
Immunisation (Influenza)	Mar-Aug 2017	75%	50.9%	58.2%	61.6%	57.3%	46.0%	59.0%	51.3%	37.5%	59.8%	60.5%	51.6%	59.9%	51.5%	53.4%	52.7%	52.7%	62.1%	45.7%	55.6%	55.5%	0
Mental Health	Year to Jun 2018	-	118	46	76	136	94	115	100	94	90	74	133	102	91	107	76	109	89	107	112	102	-
Oral Health	Jan-Dec 2016	95%	88.2%	114.6%	66.6%	106.9%	89.5%	107.0%	107.7%	127.3%	95.9%	88.4%	74.7%	95.4%	84.9%	113.2%	101.0%	72.1%	92.3%	99.6%	100.3%	106.4%	12
SUDI	2012-2016 combined	-	-	-	0.63	-	-	-	0.51	-	-	-	-	-	0.3	-	0.6	0.46	-	0.11	-	-	-

Target attained | Within 10% of target
10-20% away from target | More than 20% away from target

Māori

Indicator	Data Period	Target	Auckland	Bay of Plenty	Canterbury	Capital & Coast	Counties Manukau	Hawke's Bay	Hutt Valley	Lakes	Mid Central	Nelson Marlborough	Northland	South Canterbury	Southern	Tairawhiti	Taranaki	Waikato	Wairarapa	Waitemata	West Coast	Whanganui	Reached Target
PHO Enrolment	Jul-Sep 2018	90%	76.0%	96.0%	84.0%	85.0%	93.0%	98.0%	89.0%	101.0%	86.0%	88.0%	101.0%	83.0%	85.0%	101.0%	87.0%	94.0%	99.0%	83.0%	85.0%	99.0%	9
ASH (0-4 yrs)	Yr to Sep 17	-	6524	7426	5111	6573	6791	6434	9654	8292	6282	4171	8328	3387	5355	7960	8154	8841	11023	5827	4884	9442	0
ASH (45-64 yrs)	Yr to Sep 17	-	6638	7607	4952	6498	9182	8250	8297	8444	6924	4626	8401	4453	4550	6092	8747	9347	5420	7591	4276	8887	0
Breastfeeding (6 wks)	Jan-Jun 2017	75%	71.0%	72.0%	66.0%	70.0%	67.0%	62.0%	61.0%	65.0%	67.0%	67.0%	76.0%	63.0%	68.0%	66.0%	63.0%	65.0%	55.0%	71.0%	94.0%	67.0%	2
Breastfeeding (3 mths)	Jan-Jun 2017	70%	44.0%	48.0%	52.0%	47.0%	39.0%	40.0%	46.0%	42.0%	49.0%	45.0%	45.0%	46.0%	49.0%	37.0%	43.0%	45.0%	48.0%	53.0%	57.0%	45.0%	0
Breastfeeding (6 mths)	Jan-Jun 2016	65%	57.6%	53.6%	53.8%	54.9%	48.8%	50.2%	44.4%	57.7%	44.3%	62.3%	61.7%	37.5%	48.2%	55.4%	46.8%	49.1%	56.1%	61.5%	64.7%	57.1%	0
Breast Screening (50-69 yrs)	Apr-Jun 2018	70%	58.8%	61.4%	68.7%	68.0%	65.2%	70.0%	68.6%	64.3%	65.1%	74.1%	68.4%	67.3%	67.4%	66.6%	61.4%	58.1%	70.3%	63.8%	66.6%	72.8%	4
Cervical Screening (25-69 yrs)	Apr-Jun 2018	80%	53.6%	70.6%	63.8%	61.5%	65.8%	75.5%	67.6%	74.9%	65.1%	72.4%	69.3%	65.5%	67.5%	71.8%	76.3%	68.3%	69.8%	61.2%	64.7%	71.9%	0
Immunisation (8 mths)	Apr-Jun 2018	95%	86.1%	81.0%	94.5%	85.5%	84.0%	94.7%	86.9%	86.0%	88.3%	87.8%	81.8%	97.5%	93.5%	83.3%	80.7%	82.1%	93.0%	85.9%	87.5%	87.1%	1
Immunisation (Influenza)	Mar-Aug 2017	75%	33.1%	53.8%	41.9%	45.5%	40.0%	55.8%	46.4%	32.0%	47.9%	50.6%	50.2%	41.7%	43.9%	53.8%	42.1%	47.4%	50.9%	32.9%	48.9%	64.6%	0
Mental Health	Year to Jun 2018	-	489	172	222	509	362	385	191	340	105	169	453	133	263	231	212	462	341	284	256	179	0
Oral Health	Jan-Dec 2016	95%	65.3%	67.3%	43.7%	70.2%	73.5%	72.7%	81.1%	88.1%	94.6%	64.2%	70.5%	41.7%	65.4%	95.7%	81.4%	72.0%	67.7%	71.3%	88.1%	102.1%	2
SUDI	2012-2016 combined	-	0.73	0.61	0.92	1.92	2.15	1.54	1.36	1.18	1.49	-	1.03	-	1.96	2.37	1.55	1.75	-	-	-	2.97	0

Target attained | Within 10% of target
10-20% away from target | More than 20% away from target

- Target field is blank where there is either no target for the indicator assigned by the Ministry of Health, or where there are specific targets tailored to each DHB.
- Rheumatic fever is not displayed on this table as the Ministry of Health reports Total Population data, and data for South Island DHBs is aggregated.

National Māori Health Indicators - Oct 18
Canterbury DHB

Indicator	Target	Period	Canterbury (European /Other)	Canterbury (Maori)	Gap	Change	Trend
PHO Enrolment	90	Jul-Sep 2018	93.0	84.0	9	1	
ASH (0-4 yrs)	-	Yr to Sep 17	5905	5111	-794	-543	
ASH (45-64 yrs)	-	Yr to Sep 17	2504	4952	2448	1191	
Breastfeeding (6 wks)	75	Jan-Jun 2017	73.0	66.0	7	-1	
Breastfeeding (3 mths)	70	Jan-Jun 2017	63.0	52.0	11	6	
Breastfeeding (6 mths)	65	Jan-Jun 2016	67.2	53.8	13.4	2.8	
Breast Screening (50-69 yrs)	70	Apr-Jun 2018	75.4	68.7	6.7	1.3	
Cervical Screening (25-69 yrs)	80	Apr-Jun 2018	75.0	63.8	11.2	3.5	
Immunisation (8 mths)	95	Apr-Jun 2018	95.7	94.5	1.2	1.1	
Immunisation (Influenza)	75	Mar-Aug 2017	61.6	41.9	19.7	-1.1	
Mental Health	-	Year to Jun 2018	76	222	146	-6	
Oral Health	95	Jan-Dec 2016	66.6	43.7	22.9	14.8	
Rheumatic Fever	-	2016		0.7	0.7	-0.1	
SUDI	-	2012-2016 combined	0.63	0.92	0.29	-0.2	

CPH&DSAC – 1 NOVEMBER 2018

Canterbury District Health Board
Te Poari Hauora ō Waitaha

TO: **Chair and Members**
Canterbury District Health Board

SOURCE: **Community & Public Health and Disability Support Advisory Committee**

DATE: **15 November 2018**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

The purpose of this report is to provide the Board with an overview of the Community & Public Health and Disability Support Advisory Committee's (*CPH&DSAC*) meeting held on 1 November 2018.

2. RECOMMENDATION

That the Board:

i. notes the draft minutes from CPH&DSAC's meeting on 1 November 2018 (Appendix 1).

3. APPENDICES

Appendix 1: CPH&DSAC Draft Minutes – 1 November 2018.

Report prepared by: Anna Craw, Board Secretariat

Report approved by: Dr Anna Crighton, Chair, Community & Public Health Advisory Committee

MINUTES

Canterbury District Health Board
Te Poari Hauora ō Waitaha

DRAFT
MINUTES OF THE COMMUNITY & PUBLIC HEALTH AND DISABILITY SUPPORT ADVISORY COMMITTEE MEETING
held in the Board Room, Level 1, 32 Oxford Terrace, Christchurch
on Thursday, 1 November 2018 commencing at 9.00am

PRESENT

Dr Anna Crighton (Chair, CPHAC); Tom Callanan; Wendy Dallas-Katoa; Rochelle Faimalo; Dr Susan Foster-Cohen; Jo Kane; Ta Mark Solomon (ex-officio); Dr John Wood (ex-officio); and Hans Wouters.

APOLOGIES

Apologies for absence were received and accepted from Sally Buck; Tracey Chambers; Chris Mene; David Morrell; and Yvonne Palmer.
An apology for lateness was received and accepted from Jo Kane (9.15am).
Apologies for early departure were received and accepted from Wendy Dallas-Katoa (11.00am); Ta Mark Solomon (10.30am); and Dr John Wood (10.30am).

IN ATTENDANCE

Evon Currie (General Manager, Community & Public Health); Dr Matthew Reid (Public Health Physician, Planning & Funding); Stella Ward (Chief Digital Officer); Anna Craw (Board Secretariat); and Charlotte Evers (Assistant Board Secretariat).

Item 8

Helen Leahy, Chief Executive Officer, Te Pūtahitanga o Te Waipounamu (Whānau Ora Commissioning Agency)

Item 9

Annabel Begg, Public Health Physician, Community & Public Health
Kirsty Peel, Health in All Policies Advisor, Community & Public Health

Item 10

Gordon Boxall, Chair, Disability Steering Group
Kathy O'Neill, Team Leader, Planning & Funding
Allison Nichols-Dunsmuir, Health in All Policies Advisor, Community & Public Health

Item 11

Mark Lewis, Head of Talent, Leadership & Capability
Linda Leishman, Project Search Canterbury

Wendy Dallas-Katoa opened the meeting with a karakia.

1. INTEREST REGISTER

Additions/Alterations to the Interest Register
There were no additions/alterations to the interest register.

Declarations of Interest for Items on Today's Agenda
Item 11: Tom Callanan declared his involvement with Project Search, as a member of its Steering Group.

There were no other declarations of interest for items on today's agenda.

Perceived Conflicts of Interest
There were no perceived conflicts of interest.

2. MINUTES OF THE PREVIOUS MEETING

Resolution (15/18)
(Moved: Tom Callanan/Seconded: Ta Mark Solomon – carried)

"That the minutes of the meeting of the Community & Public Health and Disability Support Advisory Committee held on 30 August 2018 be confirmed as a true and correct record."

3. CARRIED FORWARD/ACTION LIST ITEMS

It was noted that Item 1, Flu Jabs Funding, should be made a priority for Winter 2019.

The remainder of the carried forward action list was noted.

4. COMMUNITY & PUBLIC HEALTH EXCEPTION REPORT

Evon Currie, General Manager, Community & Public Health, presented the update, which was taken as read.

There was discussion around refugee resettlement and the impact this may have on mental health services. Ms Currie advised that a recent group of six Syrian families had been well supported by their sponsors, members of the South West Baptist Church, as coordinated through Immigration New Zealand.

Dr Matthew Reid, Public Health Physician, Planning & Funding, advised that in relation to the new quota, a first tranche of 20 refugees, with origins in Eritrea and Afghanistan, will arrive in March 2019, with a total of up to 60 refugees expected for the 2018/19 year. It is believed that refugees from these countries may have had less traumatic recent experiences than those from other countries. Provided small intakes are taken at a time, it is believed there will be the capacity and resources to absorb them in the community, primary and secondary care.

An update on AllRight? Funding in North Canterbury, Hurunui and Kaikoura was discussed. Ms Currie noted that while the funding has ceased, ongoing resources and support are still available. There is potential for the campaign to be introduced at a national level.

Resolution (16/18)
(Moved: Wendy Dallas-Katoa/Seconded: Ta Mark Solomon – carried)

"That the Committee:

i. notes the Community and Public Health Exception Report."

5. SUGAR-SWEETENED BEVERAGES POSITION PAPER

Ms Currie presented the paper, which was taken as read.

Jo Kane joined the meeting at 9.15am.

This is a South Island-wide position statement, which the South Island Public Health Partnership has agreed and is now seeking approval from each of the DHBs.

It was noted that in promoting healthy environments, coming from a position of strength is important. Approval of this position statement by South Island DHBs will provide a solid basis for moving forward.

There was discussion around this being a position statement, not a strategy. It was noted that various strategies are expected to flow from the position statement.

It was noted that work will be ongoing with the Greater Christchurch Partnership group to embed the principles of the position statement once adopted.

Resolution (17/18)
(Moved: Dr Anna Crighton/Seconded: Ta Mark Solomon – carried)

"The Committee recommends that the Board:

i. endorses the South Island District Health Boards' position statement on sugar-sweetened beverages.

6. PLANNING & FUNDING EXCEPTION REPORT

Dr Reid presented the paper, which was taken as read.

There was discussion around the Maternal Health Strategy with a request that the Board be provided an update on the four agreed key components of the strategy in light of other recent Board considerations.

There was discussion around workers camps in the Kaikoura and Hurunui regions. It was noted that these are being managed well.

Resolution (18/18)
(Moved: Jo Kane/Seconded: Tom Callanan – carried)

"That the Committee recommends that the Board:

i. notes the Planning & Funding Exception Report."

7. MĀORI AND PACIFIC HEALTH PROGRESS REPORT

Dr Reid presented the update, which was taken as read, highlighting the positive movements in Māori oral health data, largely due to improved systems and the correct recording of ethnicity; and positive movements in cervical cancer screening data.

Discussion took place around:

- A decrease in flu immunization rates in over 65 year olds and possible reasons for this.
- CDHB's lack of a Maori Health Plan.
- Barriers to health.
- The size of Canterbury's Asian population and heath needs specific to that community.
- A lack of Pacific and Asian health data.

The Committee requested the following:

- A paper to its March 2019 meeting providing background on CDHB's Maori Health strategic direction, position on Maori Health Plans, legislative requirements, political environment, and CDHB's current and future priorities. Background paper also to address data issues around Pacific and Asian health.
- An update on the Te Ha – Waitaha Stop Smoking programme.
- Dashboard for National Pacific Health Indicators to be included in future reports if available.

Resolution (19/18)
(Moved: Wendy Dallas-Katoa/Seconded: Hans Wouter – carried)

"The Committee recommends that the Board:

i. notes the Māori and Pacific Health Progress Report."

8. HAUORA ALLIANCE – PRESENTATION

Evon Currie and Helen Leahy, Chief Executive Officer, Te Pūtahitanga o Te Waipounamu (Whānau Ora Commissioning Agency), presented on the South Island Hauora Alliance, highlighting the following:

- This is a collaborative cross-sector partnership between NGOs and agencies, working collectively to address South Island hauora/health from a population perspective.
- The Steering Committee is made up of a diverse range of representatives.
- First 1000 Days report, which supports and contributes to Mokopuna Ora initiatives.
- Further steps will be to provide ongoing support to Mokopuna Ora initiatives; consider the South Island Population Health Report; and contribute to national initiatives.

Ms Leahy handed out a summary of the six Mokopuna Ora initiatives, and explained in more detail what the initiatives focus on. The initiatives were commended by the Committee.

It was suggested that the definition of hauora be published in the Mokopuna Ora document.

Discussion was held around how the approach will be shared to other areas. Ongoing conversations are held by the nine iwi of the South Island in order to support and grow the Alliance.

A request was made for information to be provided on the names of Māori organisations that work with CDHB and the services they provide.

The Chair thanked Ms Leahy for her attendance.

9. CANTERBURY WELLBEING INDEX UPDATE – PRESENTATION

Annabel Begg, Public Health Physician, Community & Public Health; and Kirsty Peel, Health in All Policies Advisor, Community & Public Health presented the Canterbury Wellbeing Index Update, highlighting the following:

- The Wellbeing index was established in 2011 after the 2010 Canterbury earthquakes. The first index was produced in June 2013.

- A review was completed in 2017, with a proposal approved by the Psychosocial Governance Group in December 2017.
- The index covers 57 indicators including subjective wellbeing, education, employment and housing. There are also 19 He Tohu Ora (Māori health) indicators.
- A website is currently under development, which was demonstrated to the Committee.
- Next steps include development of the index and launching the website at the Healthy Greater Christchurch hui at the end of November.

A Committee member queried the lack of representation of cultural engagement. Ms Peel confirmed this is included under the indicator for social capital.

There was a query about where the data is sourced from. Ms Peel commented that data comes from the Te Kupenga wellbeing survey, with 16 indicators directly from the survey, 28 from multiple other agencies; as well as special requests from various other agencies and Statistics New Zealand. Ihi Research also provided some data and assistance with the project.

Ta Mark Solomon and Dr John Wood retired from the meeting at 10.30am.

The Chair commended Ms Peel and Ms Begg for their presentation and the work done by the team on the index.

INFORMATION ITEMS

- Disability Steering Group Minutes – July and August 2018
- Health Target Q4 Report
- Air Quality Monitoring/Respiratory Illness Data
- 2018 Workplan

The formal meeting concluded at 10.30am due to a loss of quorum. The remaining agenda items were considered in an informal meeting.

Confirmed as a true and correct record:

_____ _____

Dr Anna Crighton Date
Chair, CPHAC

_____ _____

Tracey Chambers Date
Chair, DSAC

DRAFT
NOTES FROM THE COMMUNITY & PUBLIC HEALTH AND DISABILITY SUPPORT ADVISORY COMMITTEE INFORMAL MEETING held in the Board Room, Level 1, 32 Oxford Terrace, Christchurch on Thursday, 1 November 2018

PRESENT

Dr Anna Crighton (Chair, CPHAC); Tom Callanan; Rochelle Faimalo; Dr Susan Foster-Cohen; Jo Kane; and Hans Wouters.

APOLOGIES

Apologies for absence were received and accepted from Sally Buck; Tracey Chambers; Wendy Dallas-Katoa; Chris Mene; David Morrell; Yvonne Palmer; Ta Mark Solomon; and Dr John Wood.

IN ATTENDANCE

Evon Currie (General Manager, Community & Public Health); Dr Matthew Reid (Public Health Physician, Planning & Funding); Stella Ward (Chief Digital Officer); Anna Craw (Board Secretariat); and Charlotte Evers (Assistant Board Secretariat).

Item 10
Gordon Boxall, Chair, Disability Steering Group
Kathy O'Neill, Team Leader, Planning & Funding
Allison Nichols-Dunsmuir, Health in All Policies Advisor, Community & Public Health

Item 11
Mark Lewis, Head of Talent, Leadership & Capability
Linda Leishman, Project Search Canterbury

10. DISABILITY STEERING GROUP UPDATE

Gordon Boxall, Chair, Disability Steering Group (*DSG*), provided an update on work being undertaken by DSG, including:

- Accessibility issues:
  - Physical and capital facilities builds.
- Improving health literacy:
  - Ensuring staff are disability aware.
  - New accessible Canterbury DHB website.
- Employment:
  - Project Search.
  - Improving experiences.
- Joining issues between front line, senior management, key stakeholders and governance.
- Refreshing priorities and maintaining awareness.
- Building relationships with the West Coast.
- Growing Maori and Pacific representation.
- Succession planning work for DSG's refresh in January 2020.

A discussion was held around the positive use of bedside boards at Burwood Hospital. There was also discussion on shared footpaths and parking issues.

11. CDHB WORKFORCE UPDATE

Mark Lewis, Head of Talent, Leadership & Capability, presented the report which was taken as read. He then went on to provide a presentation on Project Search. Linda Leishman from Project Search Canterbury was in attendance for the presentation.

The presentation highlighted the following:

- Project Search began in Cincinnati Children's Hospital in 1996.
- The project provides job skills to young people who identify as having a disability.
- Will be introduced to Older Persons Health and Rehabilitation at Burwood Hospital in 2019 and built on from there.
- This will be the first implementation of Project Search in New Zealand.
- Canterbury DHB will provide a range of work opportunities and a space for on-site education and skills training.

A brief discussion was held around the Project Search curriculum and how to match that to NZQA standards.

GENERAL BUSINESS

Stella Ward, Chief Digital Officer, confirmed that Jacqui Lunday-Johnstone, newly appointed as Executive Director of Allied Health, Scientific and Technical will start in her role on Monday, 5 November 2018. Ms Lunday-Johnstone will become the new Disability EMT lead and as such will be attending future meetings.

On behalf of the Committee, Dr Crighton thanked Ms Ward for the significant contribution she has made whilst in the role of Disability EMT lead and wished her well in her new pursuits.

The informal part of the meeting concluded at 12.17pm.

RESOLUTION TO EXCLUDE THE PUBLIC

Canterbury District Health Board
Te Poari Hauora ō Waitaha

TO: **Chair and Members**
Canterbury District Health Board

SOURCE: **Corporate Services**

DATE: **15 November 2018**

Report Status – For:	Decision	☑	Noting	☐	Information	☐

1. ORIGIN OF THE REPORT

The following agenda items for the meeting are to be held with the public excluded. This section contains items for discussion that require the public to be excluded for the reasons set out below. The New Zealand Public Health and Disability Act 2000 (the *Act*), Schedule 3, Clauses 32 and 33, and the Canterbury DHB Standing Orders (which replicate the Act) set out the requirements for excluding the public.

2. RECOMMENDATIONS

That the Board:

i resolves that the public be excluded from the following part of the proceedings of this meeting, namely items 1, 2, 3, 4, 5, 6, 7, 8, 9, 10,11, 12, 15 and the information items contained in the report;

ii. notes that the general subject of each matter to be considered while the public is excluded and the reason for passing this resolution in relation to each matter and the specific grounds under Schedule 3, Clause 32 of the Act in respect to these items are as follows:

	GENERAL SUBJECT OF EACH MATTER TO BE CONSIDERED	GROUND(S) FOR THE PASSING OF THIS RESOLUTION	REFERENCE – OFFICIAL INFORMATION ACT 1982 (Section 9)
1.	Confirmation of minutes of public excluded meetings: • 18 October 2018 • 30 October 2018	For the reasons set out in the previous Board agenda.	
2.	Individual Employment Agreement (*IEA*) Remuneration Strategy 2018/19	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
3.	Proposed Benefits & Opportunities Programme	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
4.	IP Cross-Licencing Arrangements with Streamliners NZ Limited	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
5.	HealthOne Limited Partnership Formation	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
6.	IT Disaster Recovery	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)

7.	Chair & Chief Executive's Update on Emerging Issues – Oral Reports	Protect the privacy of natural persons. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	S9(2)(a) s9(2)(j)
8.	Christchurch Hospital Review: Indicative Business Case & Site Review	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
9.	Specialist Mental Health Services Detailed Business Case	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
10.	Energy Centre – Approval to Award, Design, Manufacture & Installation of Boilers	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
11.	Annual Plan Update 2018/19	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
12.	Chief Digital Officer Report	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
13.	People Report	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
14.	Legal Report	Protect the privacy of natural persons. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations). Maintain legal professional privilege.	S9(2)(a) s9(2)(j) s9(2)(h)
15.	Advice to Board: • QFARC Draft Minutes *30 Oct 2018*	For the reasons set out in the previous Committee agendas.	

iii notes that this resolution is made in reliance on the Act, Schedule 3, Clause 32 and that the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist under any of sections 6, 7 or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982.

3. SUMMARY

The Act, Schedule 3, Clause 32 provides:

"A Board may by resolution exclude the public from the whole or any part of any meeting of the Board on the grounds that:

(a) the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist under any of sections 6, 7 or 9 (except section 9(2)(g)(i) of the Official Information Act 1982.

In addition Clauses (b) (c) (d) and (e) of Clause 32 provide further grounds on which a Board may exclude members of the public from a meeting, which are not considered relevant in this instance.

Clause 33 of the Act also further provides:

(1) Every resolution to exclude the public from any meeting of a Board must state:

(a) the general subject of each matter to be considered while the public is excluded; and

(b) the reason for the passing of that resolution in relation to that matter, including, where that resolution is passed in reliance on Clause 32(a) the particular interest or interests protected by section 6 or 7 or section 9 of the Official Information Act 1982 which would be prejudiced by the holding of the whole or the relevant part of the meeting in public; and

(c) the grounds on which that resolution is based(being one or more of the grounds stated in Clause 32)

(2) Every resolution to exclude the public must be put at a time when the meeting is open to the public, and the text of that resolution must be available to any member of the public who is present and form part of the minutes of the Board.

Approved for release by: Justine White, Executive Director, Finance & Corporate Services